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the West Virginia Medical Journal

OFFICIAL ORGAN OF
WEST VIRGINIA STATE
MEDICAL ASSOCIATION

Vol. 62 No. 1

99th Annual Meeting, The Greenbrier, August 25-27, 1966

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JAN 5 1966

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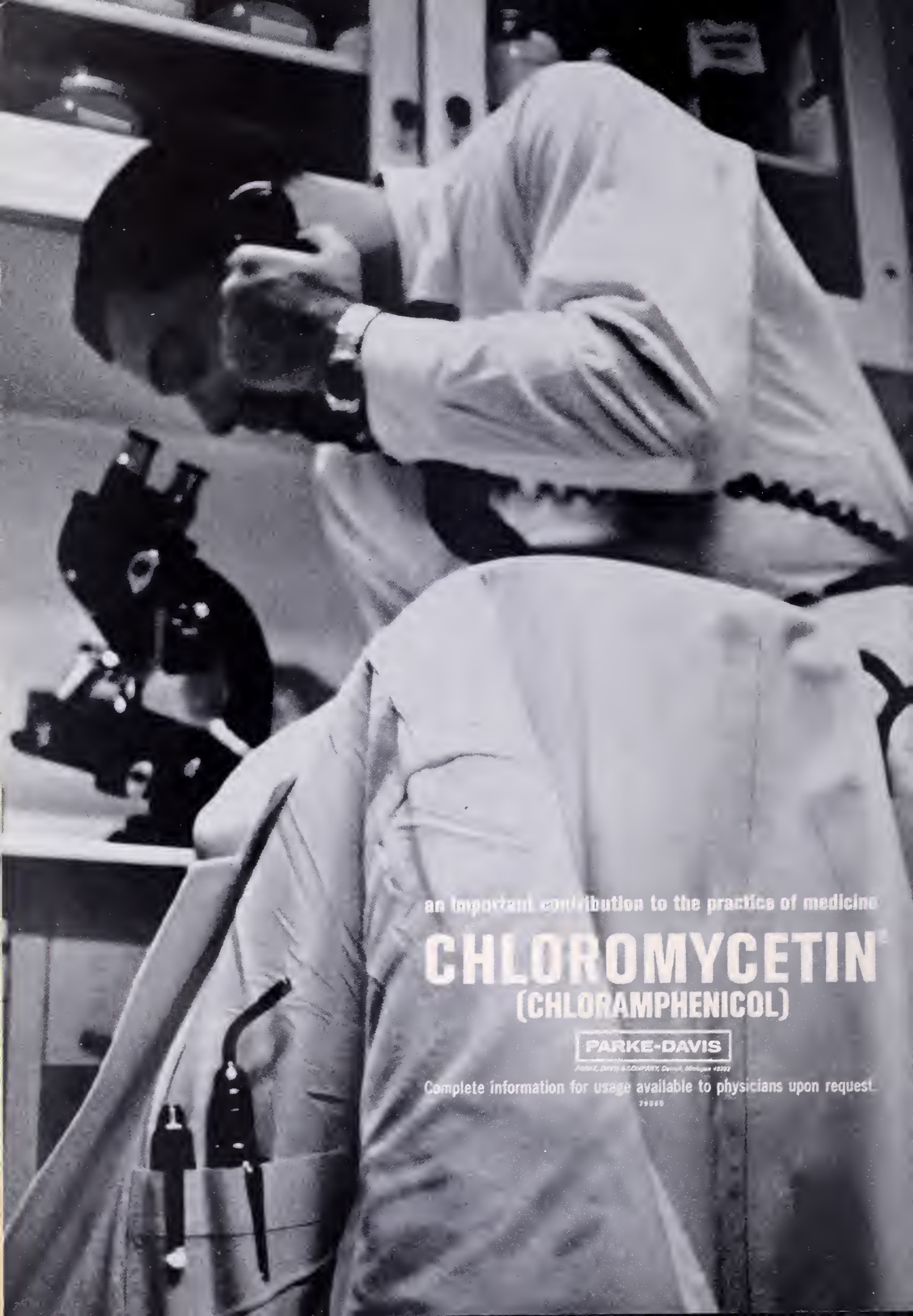
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JANUARY
1966

Vol. 62 No. 1

The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Association

Box 1031 Charleston, W. Va. 25324

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(1) Frykman, H.M.: Minn. Med., Vol. 38, Jan. 1955. (2) Poth, E.J.: The J.A.M.A., Vol. 163, No. 15, April 13, 1957. (3) McGivney, J.: Texas State Jour. of Med., Vol. 51, No. 1, Jan. 1955. (4) Stern, F. H.: Jour. of The Amer. Ger. Soc., Vol. 11, No. 3, Mar. 1963. (5) Weekes, D. J.: N.Y. State Jour. of Med., Vol. 58, No. 16, Aug. 1958. (6) Abbott, P.L.: Jour. of Oral Surg., Anes. & Hosp. Dental Serv., Vol. 19, July 1961. (7) Weekes, D. J.: E.E.N.T. Digest, Vol. 25, No. 12, Dec. 1963.

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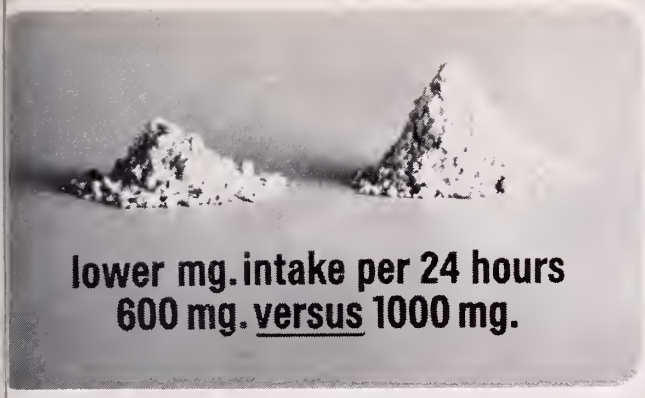

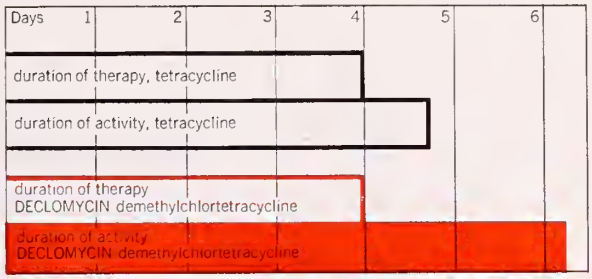

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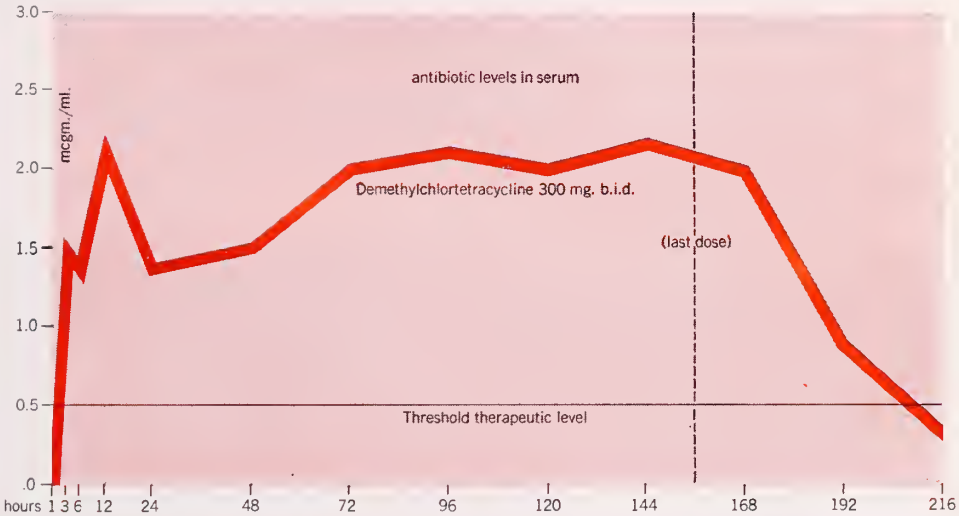

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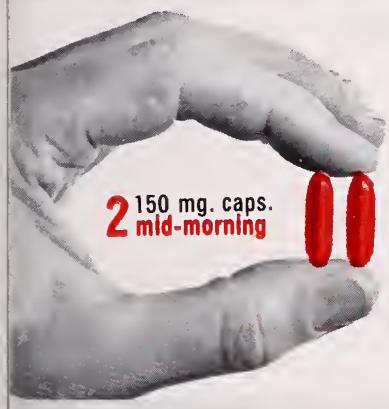

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WVU Medical Center
–News–

Dr. Edward G. Stuart, Director of the Institute of Biological Sciences at West Virginia University, has been named Acting Vice President for the WVU Medical Center.

In announcing the appointment, Dr. Paul A. Miller, President of WVU, said Doctor Stuart has agreed to fill in until a permanent appointment can be made. The post has been vacant since Dr. Kenneth E. Penrod resigned to accept a similar position at Indiana University last summer.

Doctor Stuart also has served as an Associate Professor of Pathology and as assistant to Dr. Clark K. Sleeth, Dean of the School of Medicine. He came to WVU in 1960.

Blind Children Get Examinations

The Division of Ophthalmology of the School of Medicine has begun a visitation program at the West Virginia Schools for the Deaf and Blind in Romney.

Dr. Robert R. Trotter, Chairman of the Division of Ophthalmology, and three staff members visited the institution in December at the request of Superintendent Jack W. Brady to provide free examinations. Assisting Doctor Trotter were Dr. Robert Herm, Assistant Professor of Ophthalmology, and Drs. William McFadden and Richard Richmond, both residents in ophthalmology.

Doctor Trotter said members of the staff will make periodic eye examinations at the school. Heretofore, children in need of eye examinations have been taken to Cumberland, Maryland.

"It is hoped," Doctor Trotter said, "that continuing eye care can help rehabilitate some of the blind children."

Doctor Milam Elected

Dr. D. Franklin Milam, Professor of Urology and Surgery, has been elected to the Executive Committee of the Mid-Atlantic Section of the American Urological Association.

The Section covers West Virginia, Virginia, District of Columbia, Maryland, Eastern Pennsylvania, Southern New Jersey and Delaware.

Dermatology Meeting

Two School of Medicine faculty members participated in the annual meeting of the American Academy of Dermatology which was held in Chicago, December 4-9.

Dr. William A. Welton, Chairman of the Division of Dermatology, presented two papers. They were entitled "Lipodystrophy" and "Ehlers-Danlos Syndrome."

• Compiled from material furnished by Arthur V. Ciervo, Director, Medical Center News and Information Services, Morgantown, West Virginia.

Dr. Robert S. English, Clinical Assistant Professor of Medicine, presented a paper on "Bullous Pemphigoid."

Cancer Research Seminar

The fifth in a series of nine research seminars on cancer will be conducted Tuesday, January 18, in the Basic Sciences Building.

William G. Isner, part-time instructor in the Department of Chemistry, will speak on "Infrared Spectral Studies of the Seed Pols of Annua Lunaria."

Anesthesiology Lecture

Dr. Burton S. Epstein, Assistant Professor of Anesthesiology at the George Washington University School of Medicine, lectured at the Medical Center on November 26.

The subject of Doctor Epstein's paper was "Management of the Airway in the Severely Burned Patient."

The physician's visit to WVU was sponsored by Medical Education for National Defense and the WVU School of Medicine's Division of Anesthesiology.

Pharmacologist To Go Abroad

Dr. Robert Stitzel, Assistant Professor of Pharmacology in the School of Medicine, will go to Sweden this year to study the effects of drugs on the nervous system.

Doctor Stitzel will leave July 1 and will study under a fellowship awarded by the Swedish Medical Research Council. He will study for one year under Dr. Arvid Carlsson at the University of Goteborg.

Doctor Stitzel was educated at Columbia University and the University of Minnesota. He plans to return to WVU upon completion of his studies abroad.

White House Health Conference

Dr. Clark K. Sleeth, Dean of the School of Medicine, attended the White House Conference on Health which was held in Washington, November 3-4.

United Fund

Medical Center staff members and employees contributed $10,450 to the 1965 United Fund campaign in Monongalia County.

Contributions amounted to a six per cent increase over 1964's donations. Divisions showing increases were Medicine, Basic Sciences, Dentistry and University Hospital.

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The Month in Washington

• From the Washington Office of the American Medical Association.

THE Public Health Service has expanded its "Pap" test program with a goal of providing cervical cancer tests for most women who enter hospitals and many of those who see physicians for any reason. A total of $6 million has been allotted for the expanded nationwide campaign.

Grants will be made to hospitals, medical schools, state and local health departments and non-government health groups for training of technicians, post-residency training of physicians, purchase of laboratory equipment, examination of hospital outpatients and other such expenditures.

Since last March, the American Academy of General Practice has been implementing for the PHS an office cancer detection program. A PHS spokesman termed the program "most effective," although not costly.

The PHS said it expects to achieve its goal in hospital tests within the next five years, with the number of hospitals providing this service to all adult women patients increasing each year during this period.

Hospitals providing care for the poor and medically indigent will receive first consideration in the awarding of grants. These patients have not been tested usually for cervical cancer, the PHS said. PHS Surgeon General William H. Stewart said the new hospital-based screening program reaching high risk, low-socio-economic groups offered "a truly effective" means of fighting cancer through the "Pap" test for early detection.

Although the "Pap" test was developed more than 20 years ago, only 20 per cent of the nation's 62 million adult women had received the test last year, the PHS said.

Heart Disease, Cancer and Stroke

After President Johnson named the National Advisory Council on Regional Medical Programs to advise the government on programs authorized by the Heart Disease, Cancer and Stroke Law, Dr. James Z. Appel, AMA President, expressed regret that "the AMA was not asked to submit any nominations to this important body."

"Frankly, we are disturbed that the PHS has taken this action in view of our known interest in this Act, and the inclusion before its enactment of the 20 amendments we had proposed," Doctor Appel said. "You may remember that one of the amendments incorporated into the final bill was our suggestion that the Advisory Council have final authority in approving or disapproving grant requests rather than only advisory authority as initially provided."

Nonetheless, Doctor Appel told the AMA House of Delegates in Philadelphia:

"If we provide effective leadership, and if the PHS cooperates, it may be that this law will permit the development of programs which will benefit the public and be acceptable to the profession. I cannot urge you strongly enough, therefore, to take steps now through appropriate state and local society committees to meet with medical school deans, state health department directors, teaching hospital administrators, and department heads in an effort to establish jointly a series of programs under the Act that would be wholly beneficial."

DMSO Testing Discontinued

Clinical testing of the experimental drug DMSO has been discontinued by voluntary agreement of the drug sponsors and the Food and Drug Administration. The action was prompted by reports of adverse effects on the eyes of laboratory animals. About 1,000 investigators had been testing the drug on thousands of human patients. Both the American Medical Association and FDA previously had warned that attempted self-medication with the material was dangerous.

DMSO is produced as an industrial solvent as well as grades for medical research purposes.

Birth Control Pills

A special advisory committee of non-government medical experts is conducting a comprehensive review of side-effects of birth control pills.

The Advisory Committee on Obstetrics and Gynecology was appointed in November by the Food and Drug Administration because of reports that women who had taken oral contraceptive pills had suffered thromboembolic phenomena including strokes, thrombophlebitis and pulmonary embolism, and various eye and vision manifestations. An article in the AMA's Archives of Ophthalmology reported 68 cases of eye ailments, migraine and strokes among women who had taken the pills.

As an interim measure, the FDA directed manufacturers of the pills to put on package labels two warnings—1) use should be stopped if eye problems occur, and 2) women who have had strokes should not take them.

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1,519	1963	95.2%
2,492	1964	96.7%

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Obituaries

ROBERT LITTLEPAGE CALVERT, M. D.

Dr. Robert L. Calvert, 54, of Spencer, died in Gordon Memorial Hospital in Spencer on November 21 after a long illness.

Doctor Calvert, a native of Chelyan in Kanawha County, received his M.D. degree in 1937 from the Medical College of Virginia and had practiced in Spencer since 1952. He specialized in pediatrics.

He was a member of the Roane County Board of Education and formerly served as county health officer. His memberships included the Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association.

During World War II, Doctor Calvert served as a Captain in the Medical Corps of the United States Army.

Survivors in addition to the widow include two daughters, Cornelia and Paige, both at home; three sisters, Mrs. Heber Mosby of Clarksburg, Mrs. Margaret Robinson and Mrs. E. S. Brown of Chelyan; and one brother, Russell, of Chelyan.

MILTON STONE DULING, M. D.

Dr. Milton S. Duling, 71, died on November 28 four days after he suffered a heart attack while working in his Charleston office.

A native of Spencer, Doctor Duling had practiced in Virginia for a brief time before establishing a practice in Charleston in 1924. He attended West Virginia University and received his M.D. degree in 1920 from Jefferson Medical College.

He was a member of the Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association.

In addition to the widow, survivors include: two sons, Dr. W. Edward Duling, his associate in medical practice, and Milton, Jr.; daughters, Mrs. John Dunbar and Miss Mary Katherine Duling, both of Charleston; one sister, Miss Ethel Conner of Morgantown; and two brothers, Walter of Huntington and the Rev. Hugo B. Duling of Georgia.

* * * *

COLE D. GENGE, M. D.

Dr. Cole D. Genge of Huntington died at his home on November 11 after an illness of several months. He was 58.

A native of Greenlake, Wisconsin, Doctor Genge attended Ripon College in Wisconsin and received his M.D. degree in 1934 from the Duke University School of Medicine. He had been a radiologist at Chesapeake & Ohio Hospital since 1940, when he moved to Huntington.

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E. C. Voss, M. D.

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W. F. Park, M. D.
M. E. Nugent, M. D.

Orthopedic Surgery:
C. B. Buffington, M. D.
G. B. Krivchenia, M. D.

Thoracic Surgery:
Daniel W. Dickinson, M. D.

Obstetrics and Gynecology:
Robert W. Leibold, M. D.
Robert T. Brandfass, M. D.
Hugh R. Holtrop, M. D.

Urology:
Richard D. Gill, M. D.

Neurological Surgery:
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Frank M. Hudson, M. D.

Internal Medicine:
Charles H. Hiles, M. D
Albert M. Valentine, M. D.
James A. Jacob, Jr., M. D

Psychiatry and Neurology:
Albert L. Wanner, M. D.
Stephen D. Ward, M. D.
David H. Smith, M. D.

Roentgenology:
William K. Kalbfleisch, M. D.

Clinical Laboratories:
Donna Bryan, M. T.

Technologists:
Electrocardiography:
Patricia Pastor, R. N.
Electroencephalography:
Joann Green, R. N.
June Althar, R. N.
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OBITUARIES—(Continued)

He was a member of the Cabell County Medical Society, the West Virginia State Medical Association, the American Medical Association, Southern Medical Association, the Radiological Society of North America, the American College of Radiology and the American Association of Railway Surgeons.

Survivors include the widow, Mrs. Marjorie Scruggs Genge; a son, Richard, at home; a daughter, Mrs. William H. Armstrong, Jr., of Denver; and a sister, Mrs. Roland L. Kolb of Fort Monroe, Virginia.

* * * *

CLYDE WHITLEY VICK, M. D.

Dr. Clyde W. Vick, Sr., of Bluefield, died in a hospital in that city on December 4, the eve of his 88th birthday. He had been in ill health for some time.

Doctor Vick was born in Virginia and received his M.D. degree in 1905 from the University of Maryland School of Medicine. He was an honorary member of the Mercer County Medical Society and the West Virginia State Medical Association.

He had practiced medicine in Bramwell, Sagamore and other small communities in Southern West Virginia. He retired in 1949 and moved to Bluefield.

Survivors include three sons, George W. Vick of Bluefield, Dr. Clyde W. Vick, Jr., of Petersburg, and Robert G. Vick of Birmingham, Alabama; a daughter, Miss Eugenia Vick of Bluefield; and eight grandchildren. His wife died in 1958.

Blue Shield Plans Reach Record Membership

Membership of the 85 Blue Shield Plans in the United States, Canada, Puerto Rico, and Jamaica increased 1,029,265 during the first three quarters of 1965 to a record of 57,286,041, the National Association of Blue Shield Plans reported recently.

Over half of the increase, 549,602, was acquired in the second quarter. The addition of a new plan—Windsor, Ontario—contributed 263,445 members to the second quarter gain.

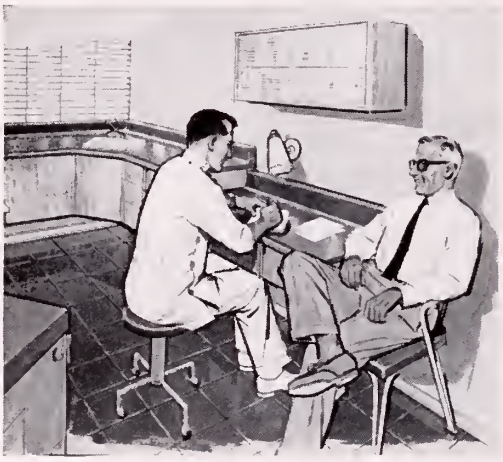
Included in the total enrollment figure is the membership of Medical Indemnity of America, Inc., a stock company wholly owned by the National Association of Blue Shield Plans.

During the first nine months of 1965, membership gains were reported by 63 Plans, 20 had losses, and two remained the same. Gains totaled 1,340,577, while losses amounted to 311,312.

Third quarter gains of 438,856 were posted by 56 Plans, with 26 Plans reporting losses of 129,412. Three Plans showed no change.

The 1.82 per cent enrollment increase in the first nine months brought Blue Shield coverage in the United States to 27 per cent of the population.

Blue Shield now covers 26.8 per cent of the Canadian population, 1.4 per cent of the Jamaican population, and 4.1 per cent of the population of Puerto Rico.



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Indications: 'Miltown' (meprobamate) is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, 'Miltown' fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of preexisting symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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County Societies

B-R-T

Dr. Murray Ferderber, Assistant Professor of Orthopedics at the University of Pittsburgh Medical School, was the guest speaker at the November meeting of the Barbour-Randolph-Tucker Medical Society, which was held at the Elkins Country Club on November 18.

Doctor Ferderber presented a paper entitled "Disabilities of the Adolescent, Adult and Aging."

Dr. Ernest G. Guy of Philippi, President of the Society, presided at the meeting which was attended by 19 members.—A. Kyle Bush, M. D., Secretary.

* * * *

CABELL

Dr. James S. Klumpp of Huntington, a Past President of the West Virginia State Medical Association, was honored at the monthly meeting of the Cabell County Medical Society which was held at the Hotel Frederick in Huntington on November 11.

Forty-seven members and guests were present for the "Dr. Jim Klumpp Night" program. Among those paying tribute to Doctor Klumpp were Dr. Walter R. Wilkinson, President of the Cabell County Medical Society; Dr. Albert C. Esposito, Chairman of the Council of the West Virginia State Medical Association; Dr. Seigle W. Parks of Charleston, President of the State Medical Association; and Dr. Jack Leckie of Huntington, President of the West Virginia Chapter of the American Academy of General Practice.

A plaque was given to Doctor Klumpp "in recognition of his services rendered to this state and to the medical profession."

Doctor Klumpp is serving the State Medical Association as Parliamentarian, Chairman of the Committee on Constitution and By-Laws, and Associate Editor of *The Journal*. He formerly headed the Committee on Medical Economics.—Harold N. Kagan, M. D., Secretary.

* * * *

FAYETTE

Dr. Cornelio Nolasco of Montgomery was the guest speaker before the regular monthly meeting of the Fayette County Medical Society which was held at Laird Memorial Hospital in Montgomery on November 10.

Doctor Nolasco presented an interesting paper on "Urological Problems." The meeting was attended by 10 members and guests.—W. P. Bittinger, M. D., Secretary.

* * * *

HARRISON

Dr. William A. Welton, Associate Professor of Medicine and Chairman of the Division of Dermatology at the West Virginia University School of Medicine, was guest speaker at the regular meeting of the Harrison County Medical Society which was held at the Stonewall Jackson Hotel in Clarksburg on December 2.

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Doctor Welton presented an interesting paper on "Teenage Dermatosis." He used slides to illustrate his lecture.

More than 40 members and guests attended the meeting.—Paul E. Gordon, M. D., Secretary.

* * * *

MARION

Mr. James M. Knowles was guest speaker at a meeting of the Marion County Medical Society which was held on November 17.

Mr. Knowles is chairman of an advisory board for a proposed new convalescent-rehabilitation center in Fairmont. He explained the proposal to the physicians.

A statement issued later by members of the Society expressed interest in additional facilities but urged that nothing be allowed to interfere with the construction of a new wing at Fairmont General Hospital.

* * * *

McDOWELL

Dr. William M. Bruch, a Bluefield pediatrician, was the guest speaker at the regular monthly meeting of the McDowell County Medical Society which was held at Grace Hospital in Welch on November 10.

Dr. Arthur Allen Carr of Welch introduced Doctor Bruch, who spoke on rubella and its effects and appearances, especially in the expectant mother during the first trimester of pregnancy and in the newborn infant.

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The following members were nominated by the Nominating Committee as officers for 1966: Dr. Charles F. McCord, President; Dr. Stephen Mamick, Vice President; Dr. John S. Cook, Secretary; and Dr. Johnny R. Hatfield, Treasurer.

Seventeen members attended the meeting.—John S. Cook, M. D., Secretary.

* * * *

MERCER

Dr. Thomas B. Baer of Bluefield was elected President of the Mercer County Medical Society at a meeting held at the West Virginian Hotel in Bluefield on November 15.

He succeeds Dr. Sam Milchin of Bluefield, Virginia.

Other new officers are: Dr. J. Elliot Blaydes, Jr., of Bluefield, Vice President; Dr. John J. Mahood of Bluefield, Secretary-Treasurer.

Mr. Charles Yearout of the Appalachian Power Company was guest speaker. Mr. Yearout gave an interesting talk on poisonous plants and told how to distinguish between poisonous and nonpoisonous snakes. —John J. Mahood, M. D., Secretary.

* * * *

MONONGALIA

Dr. G. Robert Nugent, Associate Professor of Neurosurgery at the West Virginia University School of Medicine, was the speaker at the regular monthly meeting of the Monongalia County Medical Society which was held in Morgantown on October 5.

Doctor Nugent's topic was "Brain Scan." He said this is one of the most useful procedures available to aid in the diagnosis of neurological brain lesions.

Dr. Seigle W. Parks of Charleston, President of the West Virginia State Medical Association, was guest speaker at the November 1 meeting of the Monongalia County Society.

Doctor Parks spoke on the purposes of the State Medical Association and the need for strong local societies to make it an effective organization. He discussed the proposed county officers workshop, the recent dues increase and other topics.

Dr. Stephen Dewing, a member of the Department of Radiology at the WVU School of Medicine, was admitted to membership in the county society.

Dr. George A. Curry, President of the Society, presided at the meeting which was attended by more than 40 members.—W. E. K ng, M. D., Secretary.

Change of Address

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EASTERN PANHANDLE

The Woman's Auxiliary to the Eastern Panhandle Medical Society entertained with a coffee at the home of Dr. and Mrs. C. Vincent Townsend in Martinsburg on November 17.

Guests include Mrs. Wilson P. Smith of Huntington, President of the Woman's Auxiliary to the West Virginia State Medical Association; Mrs. M. Bruce Martin of Huntington, State Chairman of AMA-ERF; and Mrs. Rupert W. Powell of Fairmont, Fourth Vice President of the State Auxiliary.

HANCOCK

Members of the Woman's Auxiliary to the Hancock County Medical Society held a luncheon meeting at the Williams Country Club in Weirton on November 16. Mrs. Leonard E. Yurko was hostess.

Tentative plans were made for the annual Doctor's Day observance. Nine members attended the luncheon.

* * * *

HARRISON

Members of the Woman's Auxiliary to the Harrison County Medical Society joined their husbands for the visit of Dr. Seigle W. Parks, President of the West Virginia State Medical Association, in November.

Doctor Parks discussed the need for attracting additional physicians, particularly general practitioners, to the State.

The Harrison County Auxiliary held a dinner meeting at the Stonewall Jackson Hotel in Clarksburg on December 2.

The Hand Bell Ringers of the Bridgeport Methodist Church presented a program of Christmas music under the direction of Mrs. Revy Golden, Jr.—Mrs. James E. Wilson, Jr.

* * * *

KANAWHA

Miss Elizabeth DePaulo was guest speaker at the regular monthly meeting of the Woman's Auxiliary to

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the Kanawha Medical Society which was held in Charleston on November 9.

Miss DePaulo, a coordinator for the West Virginia Economic Opportunity Agency, gave a report on "Project Head Start."—Mrs. J. L. Mangus, Publicity Chairman.

LOGAN

The regular monthly meeting of the Woman's Auxiliary to the Logan County Medical Society was held at the home of Dr. and Mrs. David W. Mullins in Logan on November 10.

Mrs. Walter E. Brewer, the President, presided at the meeting and the co-hostesses were Mrs. Mullins and Mrs. Mark S. Spurlock. Refreshments were served following the business meeting.

Eleven members and guests were present.—Mrs. Everett H. Starcher, Publicity Chairman.

* * * *

RALEIGH

A "silent auction" and an art exhibit were features of the regular monthly meeting of the Woman's Auxiliary to the Raleigh County Medical Society which was held at the Black Knight Country Club in Beckley on November 11.

Useful and decorative items were displayed on tables and members bid on them by writing their bids on cards. Proceeds of the auction will be applied to nurse recruitment and AMA-ERF.

Mrs. Warren D. Elliott, President of the Raleigh Auxiliary, introduced Rivers Varns, Jr., an art instructor and decorator. He discussed the paintings that were on exhibit.

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Book Reviews

PRINCIPLES OF CHEST ROENTGENOLOGY—A Programed Text—By Benjamin Felson, M. D., F. A. C. R., F. A. C. C. P., Aaron S. Weinstein, M. D., and Harold B. Spitz, M. D., Department of Radiology, University of Cincinnati College of Medicine, Cincinnati, Ohio. Pp. 234, with 164 illustrations. Paper-back. Philadelphia and London. W. B. Saunders Company, 1965. Price: $6.00.

This is a most unusual and interesting presentation.

Educators generally are intrigued, if not outrightly enthusiastic, about such aids to learning as "teaching machines." This is the first programed text in any subject in x-ray which this reviewer has seen and it opens a new vista of possibilities for other similar works which could be very useful in the training of embryo radiologists and, indeed, for all those who give some radiologic training to medical students, interns and residents in other specialties.

The sparkling and inimitable wit and humor of Dr. Benjamin Felson adds greatly to the student-interest in the present book. We think that a standard has been set in this regard which it will be difficult for others to follow.

The basic format is that of questions or statements with the answers printed in the right-hand column, and this is to be covered until the student has made up his mind as to the correct answer. Then, he uncovers the answer and having digested the implications, and having seen whether he is right or wrong, he proceeds to the next question.

The chapters cover techniques of examination, roentgen anatomy, various signs of roentgen pathology and quizzes. The questions start from ones that are very simple and elementary and proceed logically to the more difficult or advance ideas. The illustrations are numerous, well chosen and well reproduced.

Doctor Felson and his associates are to be congratulated upon pioneering in this field. The reviewer hopes that this book will receive a good reception and encourage other such programed texts.—Karl J. Myers, M. D.

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FEBRUARY
1966

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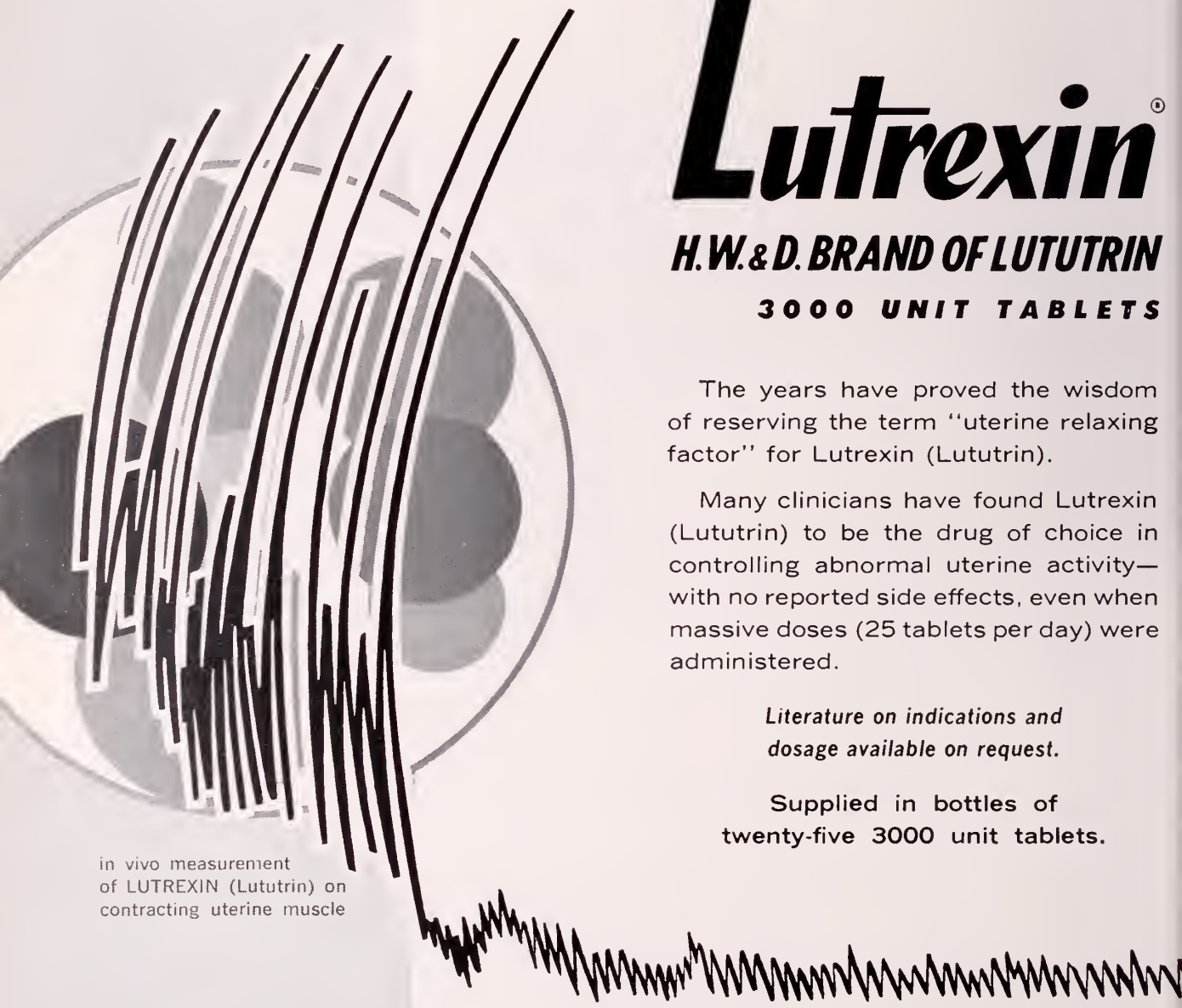

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Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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WVU Medical Center
—News—

A three-day course entitled "Infections Control in Hospitals and Institutions" will be held at the Medical Center, March 28-30. More than 125 persons from West Virginia, Ohio, Maryland and Pennsylvania are expected to enroll. They include nursing supervisors, health officers, hospital administrators and superintendents, bacteriology laboratory supervisors, nursing home personnel, infections committee members, hospital pathologists, housekeepers and faculty members from medical, nursing and public health schools.

"The purpose of the course is to discuss the seriousness of infections in hospitals and institutions and ways of controlling the problem," according to Dr. Marilyn A. Jarvis, Instructor in Public Health and Preventive Medicine in the School of Medicine.

She noted that infections "involve approximately five per cent of all hospital admissions in this country with some infection rates in hospitals as high as 15 per cent."

Noted authorities will discuss such topics as magnitude and extent of infections, the varying etiology, environmental control of infections, air and surface sampling, laundry handling and contamination, disinfection and sterilization, housekeeping, ventilation and air conditioning, isolation procedures, administrative decisions, infections committee, legal implications and liabilities, personnel education, training programs, motivation and team approach, and laboratory services.

The three-day course is being sponsored by West Virginia University, the State Department of Health, the West Virginia Hospital Association, the West Virginia State Medical Association and the West Virginia Nurses Association in cooperation with the U.S. Department of Health, Education and Welfare.

Additional information may be obtained by writing to Dr. Marilyn A. Jarvis, 2182 Basic Sciences Building, WVU Medical Center, Morgantown, West Virginia 26506.

New Faculty Members

Dr. Donald L. Kimmel of Oak Park, Illinois, has been named Professor and Chairman of the Department of Anatomy in the School of Medicine.

WVU President Paul A. Miller said Doctor Kimmel, who now holds a similar post at The Chicago Medical School, will assume the WVU position effective June 1. He will head a department recently formed by the consolidation of the departments of gross anatomy and microanatomy.

A native of Juniata, Pennsylvania, Doctor Kimmel received a B.S degree from Gettysburg College. He then was awarded masters and Ph.D. degrees from the University of Michigan.

• **Compiled from material furnished by Arthur V. Ciervo, Director, Medical Center News and Information Services, Morgantown, West Virginia.**

He has served on the faculties of the University of Michigan, Louisiana State, Baylor and Temple universities.

Doctor Kimmel is co-author of a book entitled "The Structure and Function of the Human Body" published in 1945. He also has written 49 articles for various scientific journals.

Dr. Richard D. Green, a native of Trenton, New Jersey, has joined the faculty of the School of Medicine as an instructor in the Department of Pharmacology.

Doctor Green was graduated from the Philadelphia College of Pharmacy and Science in 1961 and later received his Ph.D. degree from the University of Minnesota.

Dr. Zimmermann Presents Papers

Dr. Bernard Zimmermann, Chairman of the Department of Surgery in the School of Medicine, presented scientific papers in Canada and Minnesota during January.

On January 7-8, Doctor Zimmermann was visiting professor of surgery at McGill University in Montreal. He lectured on current surgical problems and on investigations relating to pre- and postoperative care of surgical patients.

Doctor Zimmermann also presented two papers at a symposium in Minneapolis, January 15-16. His lectures were entitled "Cardiovascular Reflexes and the Regulation of Fluid Balance" and "Fluid Management in the Postoperative Patient."

Hospital Survey

A survey conducted last fall at West Virginia University Hospital showed that 85 per cent of the patients discharged were West Virginia residents.

The survey covered 1,000 patients released during a six-week period, according to Eugene L. Staples, Hospital Director.

"Of the 1,000 patients, 848—or 85 per cent— of them were from West Virginia," Mr. Staples noted. Forty-six of the state's 55 counties were represented.

Patients also came from Pennsylvania, Ohio, Maryland, Illinois, New Jersey, New Hampshire, New York and Idaho.

Another survey, conducted on November 16, showed that 158 patients visited the out-patient clinics of University Hospital. Patients commuted an average of 35 miles to get to the clinics.

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The Month in Washington

• From the Washington Office of the American Medical Association.

THE staff of the Senate antitrust subcommittee has been investigating the rise in quinine prices. The investigation resulted from receipt by members of Congress of complaints from constituents. Many of the complaints reported a sharp rise in the price of quinidine, a quinine derivative prescribed for irregular heart beats.

The Pharmaceutical Manufacturers Association attributed the price rise to a combination of decreased supplies and rising demands. A spokesman for the association said that it had become increasingly difficult to obtain quinine's raw material, the bark of the cinchona tree. He said that Indonesia, once the principal supplier, had virtually cut off its exports of the cinchona bark to the Western world.

Other suppliers, he said, include the Congo and some South American countries. He said these sources were seriously limited, but that the shortage was not expected to reach critical proportions.

The PMA spokesman attributed the rising demand to the appearance of new strains of malaria that are resistant to synthetic drugs developed during World War II as quinine substitutes. This has caused demands for natural quinine to rise sharply in such malaria-infested areas as Vietnam.

Depressant and Stimulant Drugs

The Food and Drug Administration has taken the first steps in implementation of the new law designed to halt illegal traffic in depressant and stimulant drugs.

Acting FDA Commissioner Walton B. Rankin announced proposed regulations and appointed an advisory committe of experts as authorized by the Drug Abuse Control Amendments law enacted last year.

The Advisory Committee on Abuse of Depressant and Stimulant Drugs, which held its first meeting in late December, assisted the FDA in determining the drugs covered under the new, tighter controls effective February 1, 1966. The new law specified amphetamines and barbiturates but also authorized designation of other depressant and stimulant drugs by regulatory orders of the FDA.

At its first meeting, the advisory committee considered several classes of such drugs, including certain tranquilizers, LSD-25 and other hallucinogenic agents.

Detailed Record Required

The FDA regulations listed details of the records which the new law requires to be kept by every person manufacturing, compounding, processing, selling or otherwise distributing the designated drugs. The first required record is an inventory of stocks on hand of such drugs as of February 1. This initial inventory must contain the identity and quantity of all the specified drugs in finished form under the control of the registrant. Records thereafter must accurately list further manufacture, receipt and disposition of the drugs.

The system of record keeping was designed to permit government agents to follow the movement of the drugs—all of which are prescription drugs—from producer to consumer.

The FDA commissioner is authorized to determine that a stimulant or depressant drug has a potential for abuse, and therefore should be covered under the law, if there is evidence of:

—Individuals taking the drug in amounts sufficient to create a hazard to their health or to the safety of other individuals or the community.

—Significant diversion of the drug from legitimate drug channels.

—Individuals taking the drug on their own initiative rather than on advice of a physician or osteopath licensed by law to administer such drugs.

Most physicians won't be affected directly by the new federal regulations which state:

"The maintaining of small supplies of these drugs for dispensing or administering in the course of professional practice in emergency or special situations will not be considered as regularly engaged in dispensing for a fee."

Health and Retirement Plans

A panel of leading businessmen has warned of the dangers of relying too heavily on government for administration of health and retirement plans.

Such government programs should be used to help the sick, disabled and aged, the panel said, "only if voluntary and private means—truly and tested—cannot adequately meet society's needs . . . . Heavy reliance on government can discourage the experimentation and innovation needed to solve our health and retirement problems. Such reliance also can narrow the freedom of choice of people who prefer to meet their needs in their own ways."

This statement was a highlight of a 263-page report by the Task Force on Economic Growth and Opportunity, which was an independent group set up under the sponsorship of the U. S. Chamber of Commerce.

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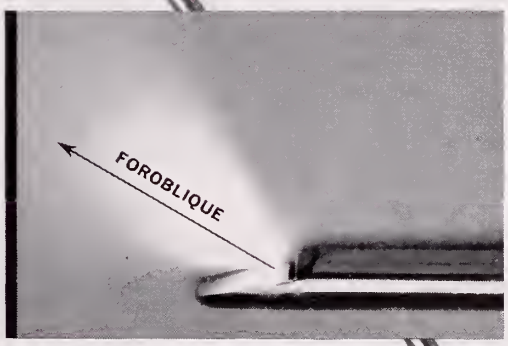

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County Societies

FAYETTE

Dr. Harry F. Cooper of Beckley was the principal guest speaker at the regular monthly meeting of the Fayette County Medical Society, which was held at the White Oak Country Club in Oak Hill on December 8, 1965.

Doctor Cooper presented an interesting talk on diseases of the esophagus and stomach. Mr. John Cutlip, County 4-H Agent, attended the meeting and spoke about statewide health projects on the Survey of Health Facilities in West Virginia.

Dr. Thomas Kerr Laird of Montgomery was elected President of the Society, succeeding Dr. Ivan H. Bush of Oak Hill. Other new officers are Drs. Clint W. Stallard of Montgomery, Vice President; William L. Claiborne of Montgomery, Secretary; and Drs. Claiborne and Joe N. Jarrett of Oak Hill, Delegates to the annual meeting of the West Virginia State Medical Association. Alternate delegates are Drs. Laird and W. B. Davis of Rainelle.

Nine members attended the meeting.—W. P. Bittinger, M.D., Secretary.

* * * *

GREENBRIER VALLEY

Dr. Stuart T. Bray of White Sulphur Springs was elected President of the Greenbrier Valley Medical Society at a meeting held at The Greenbrier in White Sulphur Springs in December. He succeeds Dr. Robert G. Shirey of Lewisburg.

Other new officers include: Dr. Claude L. Houck of Lewisburg, Vice President; and Dr. Arnold J. Brody of White Sulphur Springs, Secretary-Treasurer.

Dr. L. E. Rexrode of Marlinton was elected to membership as a transfer from the Potomac Valley Medical Society.

* * * *

HARRISON

Dr. E. Burl Randolph was the principal speaker at the regular monthly meeting of the Harrison County Medical Society, which was held at the Stonewall Jackson Hotel in Clarksburg on January 6.

Doctor Randolph presented an interesting paper on "Urological Problems in Children." He discussed indications for a complete urological work-up and presented some case studies.

Bernard Gottlieb of the Citizens Committee for Better Schools discussed the February 1 school levy election in Harrison County. Afterward, the Society endorsed the levy.

More than 35 members and guests attended the meeting.

* * * *

KANAWHA

Dr. George R. Callender, Jr., of Charleston was elected President of the Kanawha Medical Society

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at the regular monthly meeting, which was held at the Daniel Boone Hotel in Charleston on December 14.

Doctor Callender succeeds Dr. Edward Jackson of St. Albans. Dr. Ernest Q. Hull of South Charleston was elected Secretary-Treasurer.

Charleston ministers joined the physicians for a joint meeting. The Rev. Don H. Gross, Ph.D., Executive Director of the Pittsburgh Pastoral Institute, was the speaker.

* * * *

MERCER

Dr. Thomas B. Baer of Bluefield was installed as President of the Mercer County Medical Society during the annual Christmas dinner meeting, which was held at the Bluefield Country Club in December. He succeeds Dr. Sam Milchin of Bluefield, Virginia.

Dr. J. Elliott Blaydes, Jr., of Bluefield was installed as Vice President, and Dr. John J. Mahood of Bluefield began another term as Secretary-Treasurer.

* * * *

PRESTON

The Preston County Medical Society and its Woman's Auxiliary held a joint dinner meeting at the home of Dr. and Mrs. C. Y. Moser in Kingwood on December 30.

More than 25 members and guests attended the meeting.

Woman's Auxiliary

to the

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Third Vice President: Mrs. Ray M. Kessel, Logan
Fourth Vice President: Mrs. Rupert W. Powell, Fairmont
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Recording Secretary: Mrs. J. N. Jarrett, Oak Hill
Corresponding Secretary: Mrs. M. L. White, Jr., Huntington
Parliamentarian: Mrs. D. E. Greeneltch, Wheeling

LOGAN

The Woman's Auxiliary to the Logan County Medical Society met at the home of Dr. and Mrs. Ray M. Kessel in Mitchell Heights on December 8.

A luncheon was followed by a brief business meeting conducted by the President, Mrs. Walter Brewer.

Guests included Mrs. Wilson P. Smith of Huntington, President of the Woman's Auxiliary to the West Virginia State Medical Association. Mrs. Smith discussed the role of physicians' wives in AMA-ERF.

Fifteen members and guests attended.—Mrs. E. H. Starcher, Publicity Chairman.

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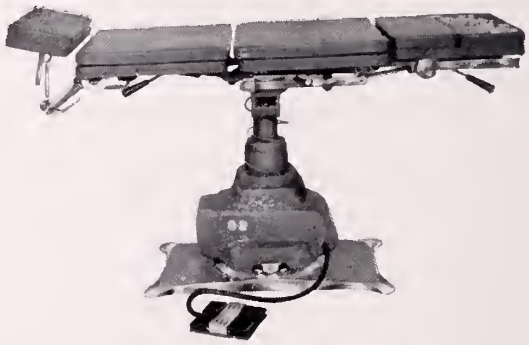

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Book Reviews

SURGERY OF THE BILIARY PASSAGES AND THE PANCREAS—By Walter Hess, Privatdozent Dr. med (Zurich). Dozent of Surgery (Basle). Translated from the German by Heinrich Lamm, Dr. Med. F.A.C.S. Operative drawings by Ingrid Schaumburg. Price $25.00. Pp. 638 with 267 illustrations. Princeton Press: Van Nostrand, 1965.

This book is a very complete work embracing surgical anatomy, anomalies, pathology and diagnosis with details of various tests and their clinical interpretation including radiomanometry of biliary and pancreatic passages as well as the portal system.

An extensive and detailed account of operative procedures and techniques is given for each pathological condition with some account of old operations; why obsolete procedures failed and new ones developed in an effort to restore physiological conditions to diseased organs. The why and why not are both explained fully and the errors causing failures of any given procedure enumerated. Normal and abnormal physiology is fully discussed as well as diagnosis from the large array of tests available today.

The same treatment is given to the duodenum and to lesser extent to the stomach as it relates to diseases of the pancreas and biliary systems.

Of particular interest are the conclusions drawn from radiomanometric studies which open up a new phase of diagnostic possibilities and seem to explain succinctly failures encountered by many surgeons. The conclusions are drawn from a sufficiently large number of the authors' own cases and from a wealth of references in both European and American literature that this book could well become a noted reference work for any surgeon. The entire book is written with a thoroughness typical of the German publications and the lists of results near the end show failures as well as successes; however, a reasonable explanation is given for failures as well as successful cases.

The book loses some of its readability in the translation but the meaning is always clearly stated—a valuable book for practicing surgeons as well as resident staff or others in training and should be included in all hospital libraries.—Andrew J. Weaver, M. D.

* * * *

FRACTURE PROBLEMS—By William Hamilton Harris, M. D., Clinical Associate in Orthopedic Surgery, Harvard Medical School; William Norman Jones, M. D., Instructor in Orthopedic Surgery, Harvard Medical School; Otto E. Aufranc, M. D., Assistant Professor of Orthopedic Surgery, Harvard Medical School, C. V. Mosby Company, St. Louis. 1965. Pp. 371 with illustrations. Price: $20.00.

This book is a systematic review of 48 cases from Massachusetts General Hospital, which were so-called "problem cases." Some of these cases have been reviewed in "Fractures of the Month in the *Journal of the American Medical Association*. This book also includes many more cases not found in the *JAMA*.

Each case is discussed by three or more orthopedic surgeons from Massachusetts General Hospital, the

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recommended treatment is discussed thoroughly, and then, the actual treatment which was carried out is discussed in detail. Practically all of these cases also have a very adequate and complete follow-up. The x-ray illustrations are excellent, the organization is very good.

I believe that any orthopedic surgeon and any traumatic surgeon would be interested and would be helped in his practice by having and using this book, since many of the problems involved are frequently found in orthopedic and traumatic practice.—Randolph L. Anderson, M. D.

* * * *

CURRENT CONCEPTS IN MEDICAL PRACTICE—By John E. Mullins, M. D., Consultant to Hepatic Clinic, Washington University School of Medicine, St. Louis, Missouri. Pp. 436 with illustrations. The C. V. Mosby Company, Missouri. 1965. Price: $10.75.

This little book of 400 pages covers current concepts of physiology, diagnosis and complications of therapy in several fields of medicine—from ophthalmology to rheumatology. Each chapter has a long reference list appended.

Print and arrangement are good and the book is easy reading.

It is probable that most of the material is present in any standard medical text. The price $10.75 places too high a value on the book's content.

Medical Expense Insurance

More than 108 million Americans have regular medical expense insurance which helps pay non-surgical doctor bills, the Health Insurance Institute reports.

The coverage is provided in many basic hospital, major medical and other health insurance policies.

This type of protection has grown from 47,248,000 persons insured at the end of 1954 to 108,717,000 persons insured at the end of 1964, according to the Institute.

The growth of this coverage is one measure of how the American people have materially broadened their health insurance protection over the past ten years, the Institute said.

At the end of 1954, more than 101 million Americans had hospital expense coverage, indicating that nearly five out of every ten persons with hospital insurance also had regular medical.

Ten years later, more than 151 million persons had hospital insurance, so that seven out of every ten persons with hospital insurance now have regular medical protection, said the Institute.

Regular medical expense protection can be expected to continue to grow, the Institute said. It estimated that as of June 1, 1965 some 111 million persons had this coverage.

Benefits paid by insurance companies to persons covered by this insurance have increased three times as fast over the last 5 years as the climb in the number of persons protected, the Institute said.

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January 7. 1966

Mr. William H. Lively
Executive Secretary
West Virginia State Medical Association
Box 1031
Charleston, West Virginia 25324

Dear Bill:

On February 1, 1966, PL 89-74 goes into effect. As has been widely publicized, its purpose is to curb drug abuse through the curtailment of illicit drug traffic. To accomplish this, the law establishes special controls over the manufacture and distribution of depressant and stimulant drugs. Among these controls is the keeping of records of the manufacture, sale, delivery, and receipt of such drugs, and it is to this matter of record-keeping, insofar as it refers to physicians, that I would like to invite your attention.

Recently, there has been some confusion as to what records a physician must keep under PL 89-74. Putting it simply, *they are not required to keep records as a consequence of this law unless, in the course of their practice, they dispense the drugs referred to and charge for them.* The law is quite clear on this, and I quote from that part of the Act relating to record-keeping:

> "The provisions of paragraphs (1, Records) and (2, Inspection) of this subsection shall not apply to a licensed practitioner . . . with respect to any depressant or stimulant drug received, prepared, processed, administered, or dispensed by him in the course of his professional practice, unless such practitioner regularly engaged in dispensing any such drug or drugs to his patients for which they are charged, either separately or together with charges for other professional services."

The key phrases in this paragraph are the words "regularly engaged" and "for which they are charged."

Further in this regard is a quote from the House Report of the Committee on Interstate and Foreign Commerce on H.R. 2 which became PL 89-74:

> "The committee intends . . . to require record-keeping and to permit inspection in the case of those physicians who maintain a supply of pharmaceuticals or medicinals in their offices from which they compound prescriptions for their patients for a fee."

The language of the Senate Committee Report is identical. Both committee reports stated that those required to keep records "involve only a very small percentage of physicians."

The proposed regulations underscore this point, indicating that ". . . maintaining of small supplies of these drugs for dispensing or administering in the course of

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professional practice in emergency or special situations will not be considered as regularly engaged in dispensing for a fee."

For those physicians who, in the course of their practice, *regularly dispense drugs and charge for them*, certain records are required to be kept for three years, effective February 1, 1966. Included are: a complete, accurate record of all depressant and stimulant drugs on hand February 1, 1966; a complete, accurate record of the kind and quantity of each drug received, sold, delivered or otherwise disposed of; the name, address (and registration number under Section 510 (e) of FDCA) of the person from whom the drugs were received, and to whom they were sold, delivered, dispensed or otherwise disposed of; and the date of the transaction. No separate form for these records will be required as long as the information specified is available.

Summing up, under PL 89-74 physicians do not have to keep records *unless* they regularly dispense the drugs covered by the Act and charge for them.

Best personal regards,

(s) C. JOSEPH STETLER,
President

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Boone	W. V. Wilkerson	Whitesville	David E. Wallace	Madison	2nd Wed.
Brooke	W. T. Booher, Jr.	Wellsburg	W. T. Booher, Sr.	Wellsburg	
Cabell	Joseph M. Farrell	Huntington	Harold N. Kagan	Huntington	2nd Thurs.
Central West Virginia	Charles T. Lively	Weston	R. L. Chamberlain	Buckhannon	As Scheduled
Eastern Panhandle	C. Vincent Townsend	Martinsburg	Frank J. Gavlas	Martinsburg	2nd Wed.
Fayette	Thomas Kerr Laird	Montgomery	William L. Claiborne	Montgomery	1st Wed
Greenbrier Valley	Stuart T. Bray	White Sulph. Springs	Arnold J. Brody	White Sulph. Sprgs.	2nd Wed
Hancock	Eli J. Weller	Weirton	Dominic A. Brancazio	Weirton	2nd Tues.
Harrison	Richard K. Hanifan	Clarksburg	Paul E. Gordon	Clarksburg	1st Thurs.
Kanawha	George R. Callender, Jr.	Charleston	Ernest Q. Hull	South Charleston	2nd Tues.
Logan	Kwan Ho Lee	Logan	Mark S. Spurlock	Logan	2nd Wed
Marion	Robert J. Sidow	Fairmont	G. Thomas Evans	Fairmont	Last Tues.
Marshall	J. W. Myers	Moundsville	David E. Yoho	Glen Dale	3rd Tues.
Mason	C. Leonard Brown	Pt. Pleasant	R. L. Slack	Pt. Pleasant	Bi-Monthly
McDowell	Charles F. McCord	Welch	John S. Cook	Welch	2nd Wed.
Mercer	Thomas B. Baer	Bluefield	John J. Mahood	Bluefield	3rd Mon.
Mingo	Alexander M. MacKay	Williamson	L. Lake Swigart	Williamson	2nd Wed.
Monongalia	Lawrance S. Miller	Morgantown	Robert Greco	Morgantown	1st Tues.
Ohio	James C. Hazlett	Wheeling	John Battaglino, Jr.	Wheeling	4th Tues.
Parkersburg Academy	Fay P. Greene, Jr.	Parkersburg	Charles H. Barnett	Parkersburg	1st Thurs.
Potomac Valley	Phillip G. Staggers	Keyser	Clinton L. Rogers	Keyser	2nd Wed.
Preston	J. V. Gainer, Jr.	Kingwood	C. Y. Moser	Kingwood	4th Thurs.
Raleigh	Richard G. Starr	Beckley	George A. Miller	Beckley	3rd Thurs.
Summers	Jack D. Woodrum	Hinton	J. W. Stokes	Hinton	3rd Mon.
Taylor	Charles A. Haislip	Grafton	Herbert N. Shanes	Grafton	Last Thurs.
Wetzel	Lemoyne Coffield	New Martinsville	Charles P. Watson	New Martinsville	Monthly
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Coffee Break

It is estimated that fifty thousand Americans stop working at least twice a day for a ten- to fifteen-minute coffee break.

A recent study from the University of California estimates that the coffe break costs $89 per employe, per year, throughout the nation, for a total sum of $4,806,000,000. Many have the idea that the coffee break is a fairly recent innovation. Actually, it started early in 1900. Associated Industries of New York State reports the coffee break originated in 1902 at the factory of the Barcalo Manufacturing Company, chair manufacturers in Buffalo, New York.

At the time the ten- and twelve-hour work day were common and it was a long time between meals. The first coffee was brewed at this factory by one of the employes in the boiler room of the plant. From this small beginning the coffee break has become a national, and even an international, institution. Executives have been known to grumble about the amount of time and money spent for this, but they should weigh the advantages. The speed up and tensions of modern working conditions, both plants and offices, makes a change of pace imperative. Unrelieved pressure is a fertile ground for mental breakdown.

We would suspect that a study comparing production with and without a coffee break would show that the coffee break increases efficiency. Many others benefit as well, including the coffee growers of South America and Africa, the coffee industry generally, and the restaurant industry.

The break undoubtedly is here to stay and should be used, not abused.—New York State Journal of Medicine.

1966 Health and Education Programs

The federal government is going to spend more on health and education programs in 1966—but not as much as originally expected, principally because of the Viet Nam war.

HEW Secretary John W. Gardner says 1966 would not be a "slowdown year" in his department because of the start of new programs in elementary and secondary education, medicare, water pollution, disease control and other areas.

History of Medical Education In West Virginia

By

Edward J. Van Liere, M. D., Ph. D.,

and

Gideon S. Dodds, Ph. D.

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MARCH
1966

Vol. 62 No. 3

The WEST VIRGINIA Medical Journal

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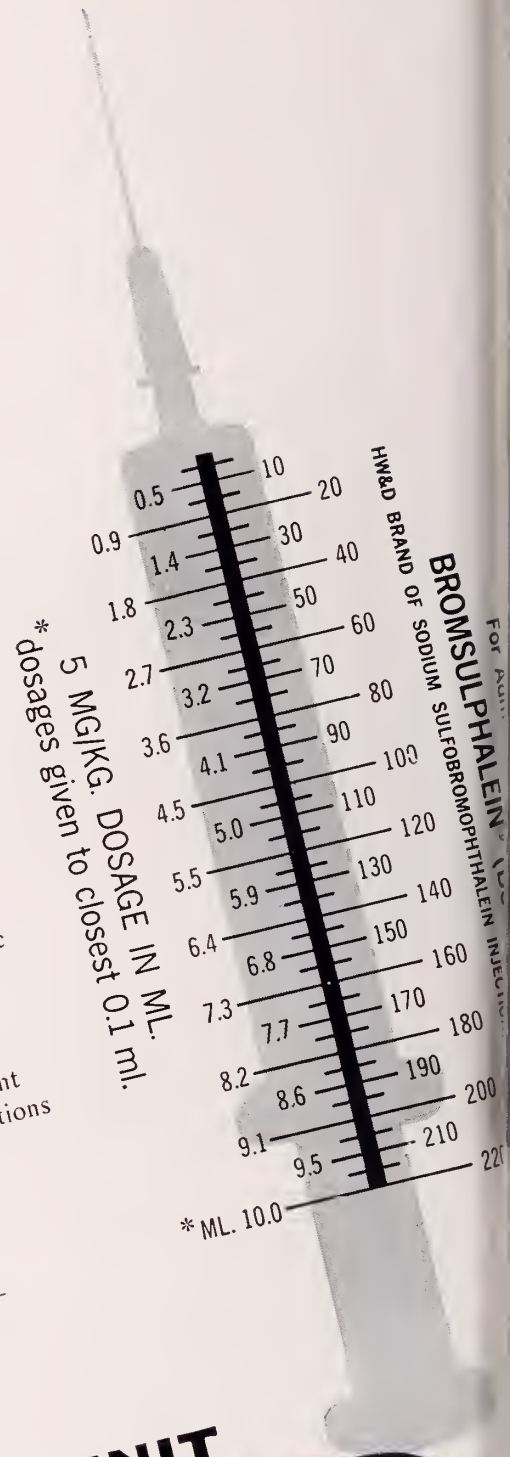

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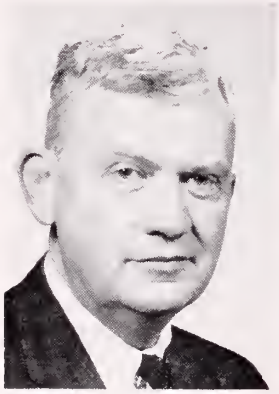
WVU Medical Center
–News–

Dr. Edward G. Stuart of Morgantown has been appointed Vice President of West Virginia University in charge of the Medical Center.

Doctor Stuart had been appointed Acting Vice President following the resignation of Dr. Kenneth Penrod in 1965. Dr. Paul A. Miller, President of WVU, said the University's Board of Governors approved Doctor Stuart's appointment at a meeting on February 5.



Edward G. Stuart, M. D.

A native of Philadelphia, Doctor Stuart received a B.S. degree in 1948 from West Chester Teachers College in Philadephia. Temple University awarded him an M. A. degree the following year. Doctor Stuart then received a Ph. D. degree in anatomy from the University of Pennsylvania in 1952 and earned his M. D. degree in 1955 from the Duke University School of Medicine.

Doctor Stuart is certified by the American Board of Pathology and has had special training in neuropathology. He joined WVU in 1960 as Associate Professor of Pathology, becoming Assistant Dean of the School of Medicine in 1961. He was named Director of the Institute of Biological Sciences in 1964 and Associate Dean the following year.

A veteran of World War II, Doctor Stuart was married in 1943 to the former Avis E. Densmore. They are the parents of 21-year-old twin sons.

Cancer Teaching Day

Dr. Warren H. Cole, Head of Surgery at the University of Illinois for the past 30 years, will be principal speaker at the Second Annual Cancer Teaching Day at West Virginia University on April 29.

At 11:15 A. M. the next day, Doctor Cole will lecture on "Carcinoma of the Colon."

Physicians, nurses and dentists from throughout West Virginia will attend the sessions, at which seven members of the faculty of the WVU School of Medicine also will speak.

Dr. Alvin L. Watne, Cancer Coordinator at WVU, said Doctor Cole will begin the program on April 29 with a paper on "Concepts in Gallbladder Disease."

• **Compiled from moteriol furnished by Arthur V. Ciervo, Director, Medicol Center News and Informotion Services, Morgontown, West Virginio.**

The paper will be presented at 4 P. M. in the Main Auditorium of the Medical Center.

Doctor Watne said the Teaching Day program "will bring out the newest advances in cancer being developed at our Medical Center and elsewhere in the nation."

"This information," he added, "will help physicians keep abreast of current advances being made in the rapidly progressing field of cancer diagnosis and treatment."

Teaching Day is being sponsored by the Charleston Foundation for Research, the West Virginia Division of the American Cancer Society and the WVU Medical Center.

Federal Grants

The U. S. Public Health Service has awarded $113,440 in grants to the Schools of Medicine and Dentistry at West Virginia University for general research.

Medicine was alloted $80,815, and dentistry will get $32,625 for use this year. Each school will determine how the money will be spent. Generally, the funds are used for three primary projects: vacation research and research training projects for students; pilot studies; and support of centralized facilities and services used by more than one department or division.

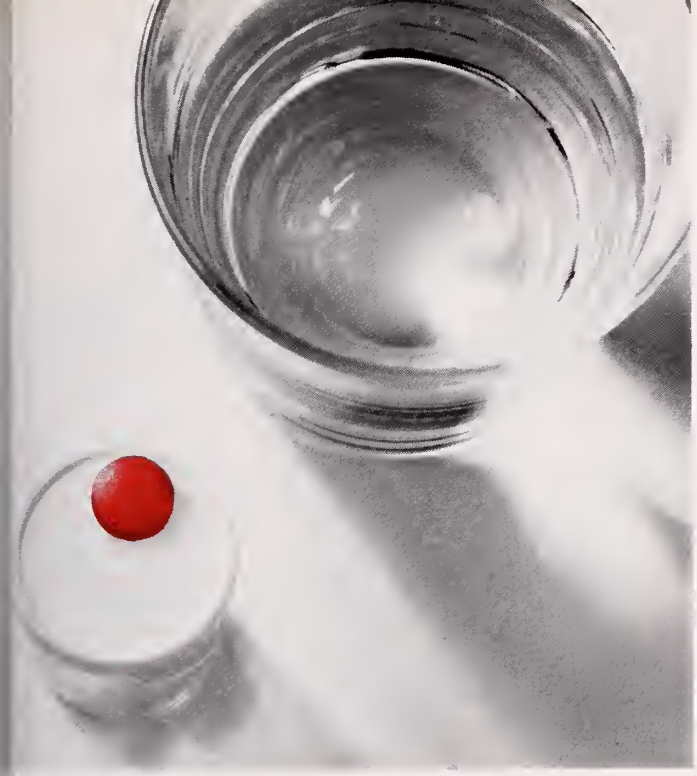
Visiting Lecturers

Dr. Robert E. Forster, President Elect of the American Physiological Society, will lecture at the Medical Center on March 18.

Doctor Forster, Professor and Chairman of Physiology in the Graduate School of Medicine at the University of Pennsylvania, will lecture to medical students at 1 P. M. At 4 P. M. he will speak on "Pulmonary Circulation" at a special lecture in the Main Auditorium.

Dr. Arthur B. Pardee, Chairman of Biochemical Sciences at Princeton University, will lecture twice at WVU. On April 4, Doctor Pardee will lecture on "Inheritance" in the Agricultural Sciences Auditorium. The following day he will speak on "Feedback Inhibition" at the Medical Center's Main Auditorium.

Both lectures are sponsored by the Institute of Biological Sciences and are open to the public.



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The Month in Washington

PRESIDENT Johnson has put a price tag of about $4.5 billion on his fiscal 1967 health programs, both domestic and international. The President's fiscal 1967 budget, for the year beginning next July 1, calls for spending about $4.3 billion on domestic health programs under the Department of Health, Education and Welfare. Cost of medicare benefits will be in addition to this total because they will be paid for by Social Security taxes.

Spending on domestic health programs would have been greater if some—such as the new heart disease, cancer and stroke program—had not been cut back because of increased costs of the Vietnam war. The cutbacks mainly were effected by requesting smaller appropriations than Congress had approved. The appropriation requested for the heart disease, cancer and stroke program was only half of the $90 million authorized by Congress.

Johnson told Congress he would submit international health legislation to: create an International Career Service in Health; help meet health manpower needs in developing nations; combat malnutrition; control and eradicate disease; and cooperate in worldwide efforts to deal with population problems.

Controlling Population Expansion

Johnson said the United States must be prepared to help developing countries that ask for aid in controlling population expansion. He said:

". . . population growth now consumes about two-thirds of economic growth in the less-developed world. As death rates be steadily driven down, the individual miracle of birth becomes a collective tragedy of want."

Two federal reports—by the President's Council of Economic Advisers and the Social Security Administration—covered medical costs and over-all national spending for health care.

The annual report of the economic council conceded that the "true" increase in medical costs may have been less than the dollar increase. The report said:

"In the most recent five years, medical costs have risen less rapidly than during the 1950's. This has been due primarily to the fact that prices of prescriptions and drugs have been declining. Also, the increase in charges for medical services—including doctors' and dentists' fees, eye examinations and eyeglasses, and hospital rates—has slowed down in comparison with the earlier period.

"The higher hospital and doctor charges reflected in the consumer price index may overstate the true increase in the cost of medical care when account is taken of the rising effectiveness of the care received. With the dramatic improvements in medical technology that have taken place over the postwar period, many patients get more real "services" from each day's stay in the hospital, or each visit to the doctor, than before."

• **From the Washington Office of the American Medical Association.**

Expenditures for Health Care

The Social Security Administration reported that the nation spent $36.8 billion in 1964 for health care, almost tripling the $12.9 billion spent in 1950. Per capita expenditures more than doubled in the 15-year period, rising from $84 to $191 per person.

Over 90 per cent of the 1964 expenditures were for health services and supplies. The balance was spent for medical research and construction of medical facilities.

There was a considerable shift in method of payment for personal health services from direct out-of-pocket payments to third-party payments. Payments by third parties which include insurance benefits, government payments and philanthropic payments, met slightly over one-third of the personal health care expenditures in 1950 and almost half of these expenditures in 1964.

Government payments continued to provide about 22 per cent of the funds for all personal health services.

Krebiozen

Both the American Medical Association and the Food and Drug Administration have warned the public against interpreting the acquittal of the promoters of krebiozen as meaning it is effective in the treatment of cancer. A federal court jury in Chicago found the promoters innocent of fraud.

"The results of a criminal proceeding should not be interpreted as establishing efficacy of the alleged new drug called krebiozen by its promoters," the AMA said. "Cancer sufferers should consult with their physicians and not try to determine for themselves what is the best course of treatment in their own individual cases."

"As far back as 1963, krebiozen was proved to be nothing more than mineral oil and creatine, a common laboratory chemical," the FDA said. "That scientific judgment still stands. The FDA will carry out its responsibility to the public by doing whatever will be necessary to keep krebiozen out of interstate commerce. We will do this as a life-saving activity. Each day a person with treatable cancer relies upon krebiozen is a day that brings him closer to death."

Obituaries

HERBERT B. COPELAND, M. D.

Dr. Herbert B. Copeland of Wheeling died in that city on January 28. He was 80.

Born in Russia, Doctor Copeland received his M. D. degree from the Chicago Hospital of Medicine and Surgery in 1915. He located in Wheeling in 1915, retiring from practice in 1962.

During World War I, Doctor Copeland served as a First Lieutenant in the Army Medical Corps. He was an honorary member of the Ohio County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow, Mrs. Yetta S. Copeland; a daughter, Mrs. Arthur Stark of New York City; two sons, M. Arnold Copeland of Allentown, Pennsylvania, and Dr. Herbert B. Copeland, Jr., of Baltimore; two brothers and seven sisters.

* * * *

WILLIAM McLAURINE HALL III, M. D.

Dr. William M. Hall III, 43, of Parkersburg, was found dead at his home on January 21.

A native of Chicago, Doctor Hall received a B. S. degree at Marietta College in 1948 and his M. D. degree from the University of Virginia four years later. He was engaged in general practice and in surgery and anesthesiology.

He served in the Armed Forces for 40 months during World War II and was discharged as a First Lieutenant.

Doctor Hall was a fellow of the American College of Anesthesiologists and was a member of the Parkersburg Academy of Medicine, the West Virginia State Medical Association and the American Medical Association.

Survivors in addition to the widow include three sons, Douglas, David and Daniel, all at home; the parents; one sister, Mrs. Robert Anderson of Chillicothe, Ohio; and one brother, John H. Hall of Santa Clara, California.

* * * *

CHARLES OTIS REYNOLDS, M. D.

Dr. Charles O. Reynolds, a retired Huntington physician, died January 24 in St. Petersburg, Florida, where he had lived for the past two years. He was 79.

A native of Proctorville, Ohio, Doctor Reynolds had practiced for 17 years with a nephew, Dr. Wilson P. Smith of Huntington. He received his M. D. degree in 1912 from the University of Cincinnati School of Medicine.

He was an honorary member of the Cabell County Medical Society, the West Virginia State Medical Association and the American Medical Association.

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widow, Mrs. Nellie Jane Corn Reynolds; and a niece, Mrs. Nellie Maud Dailey.

* * * *

BYRON WILLIAM STEELE, M. D.

Dr. Byron W. Steele of Mullens, West Virginia's "General Practitioner of the Year" in 1962, died January 29 at the home of a son in Tulsa, Oklahoma. He was 76.

A native of Moundsville, Doctor Steele attended public schools in that city. He was graduated from Marshall University in 1910 and received his M. D. degree four years later from the University of Maryland School of Medicine.

Doctor Steele was an instructor at the University of Maryland School of Medicine for one year and was on the staffs of two hospitals in Baltimore before he moved to Mullens in 1916. He practiced in Mullens until receiving a commission as a First Lieutenant in the U. S. Army Medical Corps in 1918.

He served as a surgeon at base hospitals overseas and was released with the rank of Captain in 1919. He then returned to Mullens.

Doctor Steele was an honorary member of the Wyoming County Medical Society, which he served as President in 1951; the West Virginia State Medical Association and the American Medical Association.

Doctor Steele was one of the organizers, in 1926, of the Peoples Bank of Mullens. He was a former president and chairman of the bank and for the last two years was chief stockholder.

Survivors include: the widow, the former Frances P. Ould; two sons, Dr. W. B. Steele, Jr., of Tulsa; and T. D. Steele of Roanoke, Virginia; and two brothers, Marion of Florida and Rodney of North Carolina.

* * * *

HARLAN A. STILES, M. D.

Dr. Harlan A. Stiles of Huntington died in a hospital in that city on January 15 following an extended illness. He was 54.

A native of Napierville, Illinois, Doctor Stiles located in Huntington in 1946. Since September, 1964, he had served as full-time orthopedist in the admitting and outpatient services at the Veterans Administration Hospital in Huntington.

Doctor Stiles attended North Central College at Napierville and received his M. D. degree in 1942 from the Duke University School of Medicine. During World War II, he served in the Medical Corps of the U. S. Navy.

He was a member of the Cabell County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include: the widow, Mrs. Ruth Brokenshire Stiles; the father, Dr. J. E. Stiles of Huntington; a sister, Mrs. Helen Hayslip of Huntington; and a brother, Joseph Stiles of Detroit.

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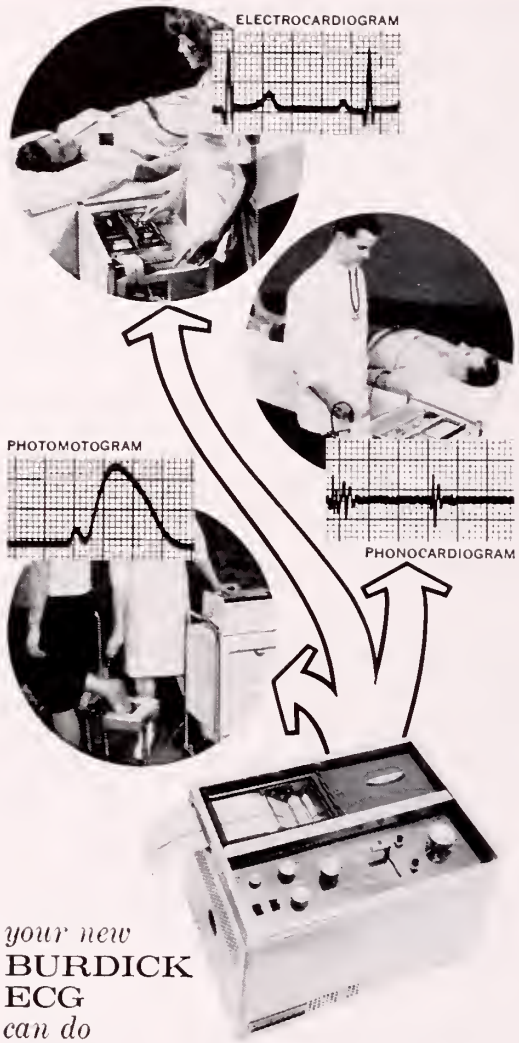

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OBITUARIES—(Continued)

MAYES B. WILLIAMS, M. D.

Dr. M. B. Williams, 75, of Wheeling, died in a Wheeling hospital on January 15.

Doctor Williams was born in Grafton and received his M. D. degree in 1912 from the University of Maryland School of Medicine. He interned in a Baltimore hospital and was the first resident physician at Ohio Valley General Hospital in Wheeling.

He began practice as a general practitioner in Wheeling in 1915 but later specialized in obstetrics and gynecology. He was health commissioner of Wheeling in 1917-18. He also was surgeon for the Baltimore and Ohio Railroad for many years. He left private practice in 1951 to become the first medical director of Ohio Valley General Hospital, a position he held until 1964.

Doctor Williams was a Past President of the Ohio County Medical Society and was an honorary member of the West Virginia State Medical Association and the American Medical Association. He had served on the Ohio County Board of Education and on the Advisory Board to the State Board of Health.

Survivors include the widow, Mrs. Valda M. Williams; a daughter, Mrs. Carl Schank of Wheeling; one brother, Earl Williams of Portland, Maine; six grandchildren and three great grandchildren.

Surgical Association Announces Plans for Congress

The Pan-Pacific Surgical Association has announced the dates for its Tenth Congress in Honolulu and the Second Mobile Educational Seminars.

The Honolulu portion of the Congress (Part I) will convene at the Princess Kaiulani Hotel on September 20 and continue through September 28. Part II and III will depart Hawaii on September 28 and visit Japan and Hong Kong, with Part II returning to San Francisco on October 10. Part III will continue on to the Philippines, Thailand, India, Singapore, Australia and New Zealand, returning to Hawaii on November 1.

Further information may be obtained by writing to Pan-Pacific Surgical Association, Room 236, Alexander Young Building, Honolulu, Hawaii 96813.

A Cease Fire on the Regulatory Front?

If the American pharmaceutical industry is to continue to lead the world in productivity and to increase its great investment in the search for ever better, safer drugs, the scientific stature of the FDA must be raised. . . . The agency and its incoming management must be given a breathing spell to absorb the vast workload it is charged with handling.

The Administration and Congress should work together to arrange this breathing spell—a temporary halt to public investigations of the FDA's stewardship —and no new FDA regulatory programs should be enacted during this period.—Walter A. Munns to Medical Society Executives Association.

County Societies

CABELL

Fifty-four members attended the regular monthly meeting of the Cabell County Medical Society which was held at the Hotel Frederick in Huntington, January 13.

Dr. William L. Neal presided in the absence of Dr. Walter Wilkinson. He later turned the meeting over to the incoming President, Dr. Joseph M. Farrell.

Dr. David A. Haught, Chairman of the Symposium Committee, announced that the next program will be conducted in September or early October and will be devoted to diabetes. Dr. C. A. Hoffman gave a comprehensive report on the Medicare program.

The Society approved a contribution of $150 for the Marshall University Science Fair, elected Dr. James Christian Branch to membership in the Society and approved the application of Dr. Thomas Altizer for associate membership.—Harold N. Kagan, M. D., Secretary.

* * * *

McDOWELL

Dr. Herbert H. Butler of Stevens Clinic Hospital in Welch presented the scientific program at the regular monthly meeting of the McDowell County Medical Society which was held at the Hospital on January 12.

Doctor Butler presented an informative talk on antibiotics and their use. He gave a practical approach to the use of antibiotics beginning with diagnosis and etiology.

Eighteen members and guests attended the meeting.

Dr. John J. Mahood of Bluefield was guest speaker at the regular monthly meeting of the McDowell County Medical Society, which was held at Grace Hospital in Welch on February 9.

Doctor Mahood's topic was "Common Skin Diseases." He showed slides on such diseases as acne, enzyme, contact dermatitis, neurodermatitis, psoriasis and warts.

The Society decided to meet jointly with the Mercer County Medical Society at the West Virginian Hotel in Bluefield on March 21.—John S. Cook, M. D., Secretary.

* * * *

MERCER

The regular monthly meeting of the Mercer County Medical Society was held at the West Virginian Hotel in Bluefield on January 17.

Doctor John J. Mahood discussed the functions and programs of the Mercer County Health Department.

Dr. Mario Cardenas was elected to membership in the Society as a transfer from Wyoming County.—John J. Mahood, M. D., Secretary.

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MONONGALIA

Dr. Clement A. Smith of Morgantown presented a paper at the regular monthly meeting of the Monongalia County Medical Society, which was held in Morgantown on January 4.

Doctor Smith's subject was "Pulmonary Edema." His paper was based on a review of the literature and a report of approximately 140 of his own cases.

Dr. Lawrance S. Miller, President of the Society, presided at the meeting, which was attended by 54 members—Robert Greco, M. D., Secretary.

* * * *

RALEIGH

Dr. H. Curtis Wood, Jr., of Fort Washington, Pennsylvania, was guest speaker at the regular monthly meeting of the Raleigh County Medical Society which was held in Beckley on January 20.

Doctor Wood's topic was "Voluntary Sterilization in the Solution of Family and Population Problems."

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HANCOCK

Mrs. Wilson P. Smith of Huntington, President of the Woman's Auxiliary to the West Virginia State Medical Association, was guest speaker at a luncheon meeting of the Hancock County Auxiliary on January 18.

* * * *

HARRISON

The Woman's Auxiliary to the Harrison County Medical Society held a dinner meeting at the Stonewall Jackson Hotel in Clarksburg on January 6.

Mr. Bernard Gottlieb, Chairman of the Citizens Committee for Better Schools, addressed the group and stressed the importance of the school levy election scheduled for February 1. The Auxiliary endorsed the levy.

More than 35 members and guests were present.

* * * *

KANAWHA

Mrs. Wilson P. Smith of Huntington, President of the Woman's Auxiliary to the West Virginia State Medical Association, and Mrs. Pat A. Tuckwiller of Charleston were speakers at a meeting of the Auxiliary to the Kanawha Medical Society which was held in Charleston on January 11.

Mrs. Tuckwiller, a Past President of the State Auxiliary, spoke on health hazards in the home.

Mrs. Tuckwiller made these points, among others:

Immunizations against disease often are neglected or put off; chemicals and pesticides should not be misused; care should be taken when disposing of containers; irons and other electrical appliances should be checked for adequate insulation; the rules of safety should be observed in boating, bicycle riding and other forms of recreation.

Mrs. Smith urged the Auxiliary members to rally to the support of AMA-ERF.—Mrs. J. L. Mangus, Publicity Chairman.

* * * *

LOGAN

Dr. Everett H. Starcher of Logan was guest speaker at the regular monthly meeting of the Woman's Auxil-

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iary to the Logan County Medical Society which was held at the home of Dr. and Mrs. Frank R. Jamison on January 26.

Doctor Starcher spoke about Medicare, and a question-and-answer period followed.

Seven members attended the meeting.—Mrs. Everett H. Starcher, Publicity Chairman.

* * * *

PARKERSBURG ACADEMY

The Woman's Auxiliary to the Parkersburg Academy of Medicine sponsored its annual Valentine Ball at the Moose Club ballroom in Parkersburg on February 5.

Proceeds were turned over to the student nurses' recreation fund at St. Joseph's and Camden-Clark Hospitals.

Mrs. Watson F. Rogers and Mrs. F. Lloyd Blair were co-chairmen for the ball.

* * * *

RALEIGH

Dr. Richard G. Starr of Beckley, President of the Raleigh County Medical Society, was guest speaker at a meeting of the Woman's Auxiliary to the Raleigh County Medical Society, which was held in Beckley January 17.

Doctor Starr observed that February is National Heart Month and chose "Coronary Risk Factors" as his topic.

Mrs. Warren D. Elliott, President of the Auxiliary, conducted a business meeting after Doctor Starr's address. Plans were approved for observance of Doctors Day on March 30.

1966 Award Winners Announced By College of Physicians

Four physicians and a philanthropist will receive awards in internal medicine and related fields at the annual meeting of the American College of Physicians which will be held in New York City, April 18-22.

Dr. Helen B. Taussig of Baltimore, President of the American Heart Association, was named to receive the John Phillips Memorial Award for distinguished contributions in internal medicine. Dr. Robert A. Phillips of Dacca, East Pakistan, a retired Navy Captain, will receive the James D. Bruce Memorial Award for distinguished contributions in preventive medicine, and Dr. Charles P. LeBlond of Montreal, Canada, will receive the ACP award for distinguished contributions in science as related to Medicine.

The ACP has selected Mrs. Albert D. Lasker of New York City as the 1966 recipient of the Edward R. Loveland Memorial Award for distinguished contributions in the health field, and Dr. Howard P. Lewis of Portland, Oregon, as recipient of the Alfred Stengel Memorial Award for outstanding service to the ACP.

This will be the first time that women have won the Phillips and Loveland Awards.

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Book Reviews

FERMENT IN MEDICINE—A study of the Essence of Medical Practice and of Its New Dilemmas—By Richard M. MaGraw, M. D., Professor of Internal Medicine and Psychiatry. University of Minnesota Medical School; and Daniel B. MaGraw, M. B. A., Lecturer in Accounting, University of Minnesota. W. B. Saunders Company, Philadelphia and London. 1966. Pp 272. Price: $6.50.

Doctor MaGraw states in the preface "This book attempts a restatement of the nature and purpose of medical practice on the assumption that these have been obscured by social and professional convention and by the very complexity of the modern medical apparatus." I believe the author accomplishes his purpose. Current issues in medicine are cleanly dissected, so they may be carefully examined, evaluated and placed in proper perspective.

It is difficult to single out issues of special importance since all are interrelated. The need of patients for comprehensive care in which physical, emotional, social and economic problems are considered is well recognized. New discoveries in the medical sciences are reported every day. It is impossible for the individual physician to master this new information and offer his patient the best available treatment for each disease he might encounter. The general practitioner has traditionally filled the role as coordinator. For a variety of reasons there are fewer general practitioners available today while the demands for service are increasing. Several possible solutions to this problem are discussed.

The hospital rather than the doctor is becoming the resource to which people turn when they are in need of help. The reasons for this are complex. The availability of a "medical care team" is an important factor. If present trends continue hospitals will become responsible for the care of all acute illnesses. Office practice will be primarily concerned with chronic illnesses and preventative procedures.

The chapter on the doctor-patient relationship is especially thought provoking. Most physicians who have considered the problem agree there is more to this relationship than the sum of the individual roles played by each. An interaction occurs which accounts for the patient's acceptance of the offered therapy and satisfies the physician's ego demands. The importance of this relationship in determining the quality of medical care a patient receives has not been studied. The term has been used for political advantage by physicians fearful of social or economic change. "It has become a defense against change and has been correspondingly reacted against as a political slogan rather than given the serious consideration it merits."

Other chapters consider the effect of research, medical specialization, other health professions and sup-

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porting technical workers, prepayment plans and other forms of health insurance and automation on the practice of medicine.

Only in the Epilogue does Doctor MaGraw take a personal stand on any of the issues he discusses. It is of little moment whether we agree with Doctor MaGraw's point of view. It is vital that all physicians become interested in and informed about the issues he raises. I am not aware of another source that so clearly defines the issues and presents the background information necessary to develop a beginning understanding of problems facing medicine today. This book is must reading for all physicians and medical students.
—Charles E. Andrews, M. D.

ARC Announces Guidelines For Health Program

The Appalachian Regional Commission has adopted a set of criteria and guidelines to assist in the administration of the $69 million health program under the Appalachian Development Act.

The criteria and guidelines were recommended by the Appalachian Health Advisory Committee. The Act authorizes an expenditure of $69 million in federal funds, to be used with state funds, for the construction and operation of multi-county demonstration health centers in the 12-state region.

The report states:

—Comprehensive health services should include health education, personal preventive services, diagnostic and therapeutic services, rehabilitative and restorative services, and community-wide environmental health services.

—Comprehensive personal health service should be readily accessible on a continuously available basis. Frequently needed on-going services should be adapted to each individual's physical and social environment. The emphasis should be on continuing care of persons, rather than on episodic treatment of categorical diseases.

—The delivery of these services should be so organized as to encourage development of a continuing relationship between the patient, his physician, and the other professional and supporting health personnel concerned with the direct provision of services.

—Encouragement should be given to the full use of existing resources, supplemented when necessary, by coordinated additional public and private resources.

The guidelines for reviewing projects, in light of the above criteria, include five categories: the rationale for selection of an area, a description of the program, administration, evaluation of the services in light of the objectives, and financing.

The Health Advisory Committee, headed by Dr. Paul A. Miller, President of West Virginia University, will provide continuing advice and guidance to the Commission on Appalachian health matters.

OFFICERS OF COMPONENT SOCIETIES

Society	President		Secretary		Meetings
Barbour-Randolph-Tucker	Homer D. Martin	Dailey	A. Kyle Bush	Philippi	3rd Thurs.
Boone	W. V. Wilkerson	Whitesville	David E. Wallace	Madison	2nd Wed.
Brooke	W. T. Booher, Jr.	Wellsburg	W. T. Booher, Sr.	Wellsburg	
Cabell	Joseph M. Farrell	Huntington	Harold N. Kagan	Huntington	2nd Thurs.
Central West Virginia	Charles T. Lively	Weston	R. L. Chamberlain	Buckhannon	As Scheduled
Eastern Panhandle	C. Vincent Townsend	Martinsburg	Frank J. Gavlas	Martinsburg	2nd Wed
Fayette	Thomas Kerr Laird	Montgomery	William L. Claiborne	Montgomery	1st Wed
Greenbrier Valley	Stuart T. Bray	White Sulph. Springs	Arnold J. Brody	White Sulph. Sprgs.	2nd Wed.
Hancock	Eli J. Weller	Weirton	Dominic A. Brancazio	Weirton	2nd Tues.
Harrison	Richard K. Hanifan	Clarksburg	Paul E. Gordon	Clarksburg	1st Thurs.
Kanawha	George R. Callender, Jr.	Charleston	Ernest Q. Hull	South Charleston	2nd Tues.
Logan	Kwan Ho Lee	Logan	Mark S. Spurlock	Logan	2nd Wed
Marion	Robert J. Sidow	Fairmont	G. Thomas Evans	Fairmont	Last Tues.
Marshall	J. W. Myers	Moundsville	David E. Yoho	Glen Dale	3rd Tues.
Mason	C. Leonard Brown	Pt. Pleasant	R. L. Slack	Pt. Pleasant	Bi-Monthly
McDowell	Charles F. McCord	Welch	John S. Cook	Welch	2nd Wed.
Mercer	Thomas B. Baer	Bluefield	John J. Mahood	Bluefield	3rd Mon.
Minga	Alexander M. MacKay	Williamson	L. Lake Swigart	Williamson	2nd Wed
Monongalia	Lawrance S. Miller	Morgantown	Robert Greco	Morgantown	1st Tues.
Ohio	James C. Hazlett	Wheeling	John Battaglino, Jr.	Wheeling	4th Tues.
Parkersburg Academy	Fay P. Greene, Jr.	Parkersburg	Charles H. Barnett	Parkersburg	1st Thurs.
Potomac Valley	Phillip G. Staggers	Keyser	Clinton L. Rogers	Keyser	2nd Wed.
Preston	J. V. Gainer, Jr.	Kingwood	C. Y. Moser	Kingwood	4th Thurs.
Raleigh	Richard G. Starr	Beckley	George A. Miller	Beckley	3rd Thurs.
Summers	Jack D. Woodrum	Hinton	J. W. Stokes	Hinton	3rd Mon.
Taylor	Charles A. Haislip	Grafton	Herbert N. Shanes	Grafton	Last Thurs.
Wetzel	Lemoyne Coffield	New Martinsville	Charles P. Watson	New Martinsville	Monthly
Wyoming	Aarom Boonsue	Mullens	Jorge Piedra	Mullens	Quarterly

APRIL
1966

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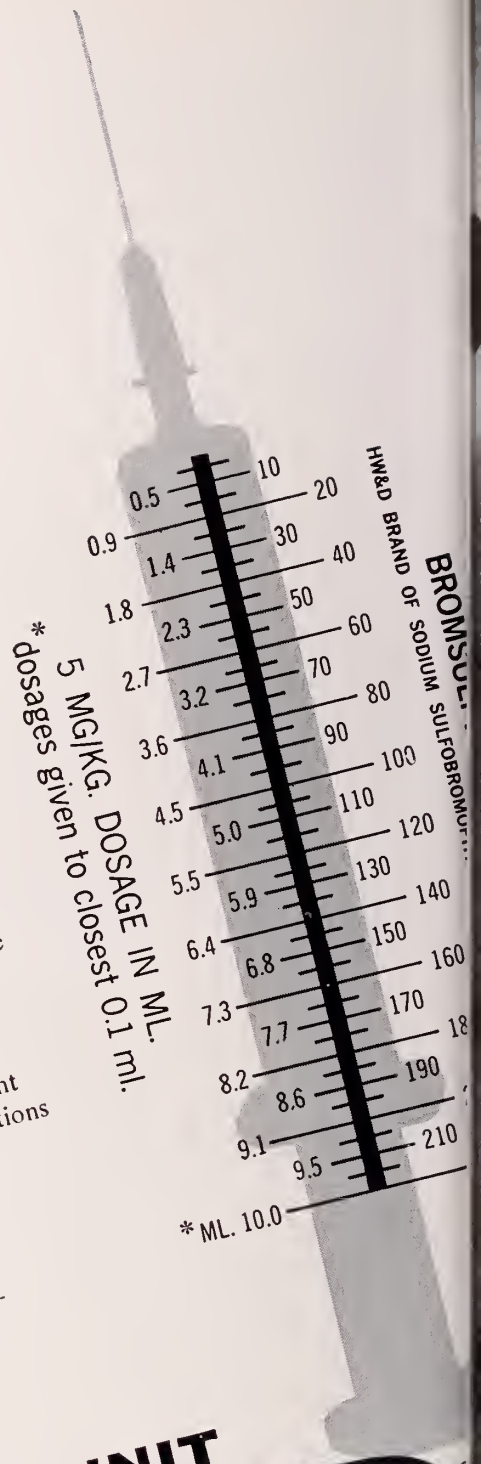

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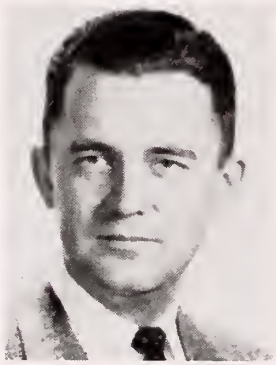
WVU Medical Center
—News—

DR. Warren H. Cole will be featured speaker at the Second Annual Cancer Teaching Day Program, which will be held at the Medical Center on April 29.

Doctor Cole has been Professor and Chairman of the Department of Surgery at the University of Illinois for the past 30 years.



Alvin L. Watne, M. D.

Warren H. Cole, M. D.

The program will begin at 9 A.M. in the main auditorium. Doctor Cole will present a paper on "Carcinoma of the Colon" at 11:15 A.M. At 4 P.M. on the preceding Friday, Doctor Cole will deliver the second Harry B. Zimmermann lecture on "Concepts in Gallbladder Disease."

Dr. Alvin L. Watne, Cancer Coordinator at the Medical Center, said the following faculty members also will present papers on April 29:

"Abdominal Tumors in Children—Diagnosis and Treatment"—Barbara Jones, M. D.

"Role of Catecholamines in the Diagnosis of Neuroblastoma"—Enid Gilbert, M. D.

"Abdominal Lymphoma"—John Harley, M. D.

"Extended Surgical Treatment of Recurrent Cervical Cancer"—Dean R. Goplerud, M. D.

"Carcinoma of the Esophagus—A Combined Approach"—Alvin L. Watne, M. D.

"Diagnosis and Treatment of Adrenal Tumors"—Walter H. Moran, M. D.

"Use of the Gastrocamera in Diagnosis"—William Anderson, M. D.

Physicians, nurses and dentists from throughout West Virginia will attend the program, which is being sponsored by the Charleston Foundation for Research, the West Virginia Division of the American Cancer Society and the Medical Center.

• **Compiled from material furnished by Arthur V. Ciervo, Director, Medical Center News and Information Services, Morgantown, West Virginia.**

Physiologist Will Lecture

Dr. David Greenfield, an internationally known physiologist, will present two lectures at the Medical Center on April 22.

Doctor Greenfield, who is Professor of Physiology at St. Mary's Hospital Medical School, University of London, will speak to the medical faculty and students in the Basic Sciences Building at 1 P.M. At 4 P.M. in the main auditorium, he will speak on "Human Circulatory Responses to Gravitational Stress." That talk will be open to the public.

Medical Librarian Takes Leave

Mr. Alderson F. Fry, Librarian at the Medical Center Library, has taken a two-month leave of absence to help organize and plan libraries in Trinidad, Jamaica and Venezuela.

Mr. Fry, who left Morgantown on February 27, has a wide reputation for his ability to plan libraries in the health sciences.

Dr. Tarnay Presents Paper

Dr. Thomas J. Tarnay, Instructor in Surgery, presented a paper entitled "Surgery in the Hemophiliac Patient" before the Central Surgical Association in Chicago on March 5.

The paper was co-authored by Drs. Bernard Zimmermann, Chairman of the Department of Surgery, and Dr. Mabel M. Stevenson, Instructor in Clinical Pathology.

Cancer Research Seminar

A seminar on the "Role of Radioactive Isotopes in Cancer Detection" will be held at the Medical Center on April 19, beginning at 7:30 P.M.

Dr. George G. Green, Associate Professor of Radiology, will conduct the seminar, which is one of a series of nine seminars on cancer research being held at the Medical Center this year.

Dr. Zimmermann Presents Papers

Dr. Bernard Zimmermann, Chairman of the Department of Surgery of the School of Medicine, gave two lectures at the 21st annual Post-graduate Course in Surgery which was held at the University of Kansas Medical Center, February 21-24.

Doctor Zimmermann's papers were entitled, "Diagnosis and Management of Adrenal Tumors," and "The Use of Steroids in Surgical Patients."

at Merck Sharp & Dohme...

understanding... precedes development

The development of chlorothiazide and probenecid were events of major importance, but perhaps even more important for the future was the Renal Research Program by which they were developed. When Merck Sharp & Dohme organized this program in 1943, it was expressing in action some of its basic beliefs about research:

• Many problems connected with renal structure and function were still undefined or unsolved. The Renal Research Program would begin its basic research in some of these problem areas.

• From knowledge thus acquired might come clues to the development of new therapeutic agents of significant value to the physician.

For example, the Renal Research Program put fifteen years into this search before chlorothiazide became available. But because these years had first led to a greater understanding of basic problems, the desired criteria for chlorothiazide existed before the drug was developed.

Along with other research teams at Merck Sharp & Dohme, the Renal Research Program continues to add new understanding of basic problems—understanding which will lead to important new therapeutic agents.

MSD MERCK SHARP & DOHME Division of Merck & Co., Inc., West Point, Pa.

where today's theory is tomorrow's therapy

The Month in Washington

• **From the Washington Office of the American Medical Association.**

THE Department of Health, Education and Welfare has issued strict guidelines prohibiting racial segregation in hospitals receiving money from the government. The department said in a policy statement that schools, hospitals and nursing homes must adhere to the guidelines to continue receiving federal funds under the Civil Rights Act of 1964.

Surgeon General William H. Stewart of the Public Health Service said more than 10,000 hospitals receiving federal funds had been sent new rules and compliance reports. He said such hospitals must not separate or discriminate on the basis of race or national origin in the care and treatment of patients.

Hospitals are being asked "whether patients are assigned to all rooms and facilities without regard to race, color, or national origin, whether all persons are allowed to use entrances, admission offices, waiting rooms, dining areas and cafeterias, toilets and lavatories, and other service facilities; whether the hospital accepts and aproves applications for staff privileges and training without regard to race, color, or national origin; and other similar questions," according to the HEW statement. "An up-to-date patient census by race must be indicated on the questionnaire, as must a breakdown by race of physicians holding staff privileges.

'If evidence of discriminatory practice is indicated in the returned questionnaire, the specific areas of failure to comply will be pointed out. The hospital will then be given an opportunity to eliminate its discriminatory practices as quickly as possible. Where discrimination persists, the hospital will be excluded from any new federal assistance programs, such as Health Insurance for the Aged (Medicare), which begins on July 1. When negotiations fail to achieve compliance, steps will be taken . . . to terminate present assistance, or compliance will be secured through enforcement by the courts.

The Office of Equal Opportunity is administratively located in the Office of the Surgeon General and will be headed by Mr. Robert M. Nash. It will employ a staff with special competencies and responsibilities in review and investigation of complaints, evaluation of complaint and compliance reports, public information activities, fiscal and statistical analysis, compliance negotiations, and development of recommendations for corrective action within the law, and will include experts in such areas as law, contracts, professional education and project grants, hospitals and nursing homes, and state and local health agencies.

The American Medical Association supports a legislative proposal for the federal licensing of dealers in research cats and dogs to protect such pets from theft and insure their humane care.

The AMA opposes licensing of research laboratories themselves and sees no need to include other research animals in such a federal program.

In a statement submitted to House Agriculture Committee when it was considering such legislation, the AMA said:

". . . We firmly agree that any improper practices which do exist in the procurement of experimental animals should be corrected. . .

"The AMA supports the purposes of the provisions of the bill which afford protection to owners of cats and dogs from the practice of pet stealing," the AMA statement said. "The Association urges, however, that the provisions with respect to the licensing of research facilities (and the setting of standards), be deleted. We further urge that the bill be restricted to cats and dogs, and not include other vertebrate animals."

The AMA said there is no need for the government to supervise laboratories because "the standards of animal care in research facilities in the United States are generally high" and voluntary efforts "are effectively accomplishing the goal of maintaining good animal care in the laboratory."

VA 'Home Town' Program

The Veterans Administration is planning a three-state test of a simplified method of administering its so-called "home town" program under which eligible veterans are treated by local physicians on a fee-for-service basis.

Alabama, Indiana and Colorado were selected for pilot programs beginning next July 1.

Under the experimental program, veterans entitled to treatment on a fee basis will receive an identification card stating the conditions for which he may be treated. Veterans then may seek treatment when they need it from doctors of individual choice. Doctors will treat the patient to the extent they believe is needed and bill the VA for "customary and usual" fees. Physicians will be asked to submit medical reports only when there is a significant change in a veteran's service-connected condition. A schedule of maximum fees will be maintained confidentially by agreement with the state medical society and fees in excess of the maximum will be reduced.

The human spine is not engineered for prolonged sitting at desks, pianos, typewriters and drafting boards. The stresses set up by the heavy, forward-tilted head and trunk, balanced precariously on an insufficient base, result in strain of the dorsal musculature, particularly at the low lumbar level.

The unusual muscle-relaxant and analgesic properties of 'Soma' make it especially useful in the treatment of low back sprains and strains. 'Soma' is widely prescribed ☐ **to relieve pain** ☐ **to relax muscles** ☐ **to restore mobility.**

Indications: 'Soma' is useful for management of muscle spasm, pain, and stiffness in a variety of inflammatory, traumatic, and degenerative musculoskeletal conditions. It also may act to normalize motor activity in certain neurologic disturbances.

Contraindications: Allergic or idiosyncratic reactions to carisoprodol.

Precautions: 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

Side Effects: The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

Dosage: Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white tablets and 250 mg. orange, two-piece capsules.

Before prescribing, consult package circular.

for the relief of low back sprains and strains

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(CARISOPRODOL)

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Annual Audit, 1965

The annual audit of receipts and disbursements of the West Virginia State Medical Association for the calendar year 1965 has been completed by the firm of Fitzhugh, Erwin, McKee and Hickman, Certified Public Accountants of Charleston. The complete audit, with letter of transmittal, follows:

FITZHUGH, ERWIN, McKEE & HICKMAN
Certified Public Accountants
500 Kanawha Banking & Trust Building
Charleston, West Virginia 25301

West Virginia State Medical Association
Charleston, West Virginia

We have examined the summary statement of cash receipts and disbursements of the West Virginia State Medical Association and the statements of cash receipts and disbursements by funds for the year ended December 31, 1965, and the statement of securities owned at December 31, 1965. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying summary statement of cash receipts and disbursements and the statements of cash receipts and disbursements by funds present fairly the recorded cash transactions of the West Virginia State Medical Association for the year ended December 31, 1965, and securities owned by the Association at December 31, 1965.

FITZHUGH, ERWIN, McKEE & HICKMAN

Charleston, W. Va.
January 31, 1966

SUMMARY STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS CALENDAR YEAR 1965

CASH IN BANK—JANUARY 1, 1965		$ 25,127.08
RECEIPTS		
Dues—see footnote	$ 66,210.00	
Interest on U. S. Bonds	592.92	
Collection Commission on A.M.A. Dues	549.67	
Advertising	22,085.76	
Emblems sold	35.75	
Subscriptions	249.50	
Exhibit space sold	7,302.50	
Dues collected for A.M.A.	55,620.00	
Interest on savings	267.63	
Repayments to Medical Scholarship Fund	100.00	
Contributions to Medical Scholarship Fund	535.00	
Refunds	1,613.98	
Employee contributions — Employee Benefit Plan	437.28	
Total Receipts		155,599.99
		180,727.07
DISBURSEMENTS		
General Fund	52,477.52	
Medical Journal Fund	31,212.38	
Convention Fund	11,258.50	
Dues forwarded to A.M.A.	55,620.00	
Medical Scholarship Fund	8,076.48	
Public Service Fund	878.33	
Total Disbursements		159,523.21
CASH IN BANK—DECEMBER 31, 1965		$ 21,203.86
	1-1-1965	12-31-1965
Cash in bank—Savings Account	6,624.49	6,892.12
Cash in bank—Checking Account	18,502.59	14,311.74
Total	$ 25,127.08	$ 21,203.86

Membership dues as reflected above includes 1966 dues of $6,960.00 collected in December, 1965.

THE WHEELING CLINIC

EOFF AT 16th STREET

WHEELING, WEST VIRGINIA

General Surgery:
J. O. Rankin, M. D.
C. D. Hershey, M. D.
E. C. Vass, M. D.

Ophthalmology:
W. F. Park, M. D.
M. E. Nugent, M. D.

Orthopedic Surgery:
C. B. Buffington, M. D.
G. B. Krivchenia, M. D.

Thoracic Surgery:
Daniel W. Dickinson, M. D.

Obstetrics and Gynecology:
Robert W. Leibald, M. D.
Robert T. Brandfass, M. D.
Hugh R. Haltrap, M. D.

Urology:
Richard D. Gill, M. D.

Neurological Surgery:
James S. Rogers, M. D.
Frank M. Hudson, M. D.

Internal Medicine
Charles H. Hiles, M. D.
Albert M. Valentine, M. D.
James A. Jacob, Jr., M. D.

Psychiatry and Neurology:
Albert L. Wanner, M. D.
Stephen D. Ward, M. D.
David H. Smith, M. D.

Roentgenology:
William K. Kalbfleisch, M. D.

Clinical Laboratories:
Donna Bryan, M. T.

Technologists:
Electrocardiography:
Patricia Pastor, R. N.
Electroencephalography:
Joann Green, R. N.
June Althar, R. N.
Roentgenology:
Evelyn Forester, R. T.

Administration:
Lester L. Cline, Manager
W. R. Lee, Assistant Manager

GENERAL FUND

Statement of Cash Receipts and Disbursements Calendar Year 1965

BALANCE—JANUARY 1, 1965		$ 12,000.08
RECEIPTS		
Dues (Allocated to General Fund)—see footnote	$ 50,310.00	
Interest on U. S. Bonds	417.92	
Collection Commission on A.M.A. Dues	549.67	
Refunds—Miscellaneous	227.26	
Refunds—A.M.A.	1,059.28	
Employee contribution — Employee Benefit Plan	437.28	
Total Receipts		53,001.41
		65,001.49
DISBURSEMENTS		
Salaries—Executive Secretary (75%)	10,500.00	
—Office	13,711.77	
Office supplies and expense	3,694.06	
Office equipment and furnishings	59.24	
Office rent	3,180.00	
Library expense	424.87	
Telephone and telegraph	2,906.17	
Postage	1,696.15	
Travel	1,795.96	
Legal and auditing	1,870.00	
Legislative bulletins and expense	1,361.35	
Payroll taxes	546.69	
Unemployment tax	80.04	
Mimeographing	411.65	
Expense of Council and Committee meetings	5,836.88	
Miscellaneous expense	1,509.95	
Employee Benefit Plan	1,998.90	
Public information	552.25	
Dues and subscriptions	341.59	
Total Disbursements		52,477.52
BALANCE—DECEMBER 31, 1965		$ 12,523.97
Due from Medical Journal Fund	10,893.35	
Due from Public Service Fund	1,630.62	
Fund Balance	$ 12,523.97	

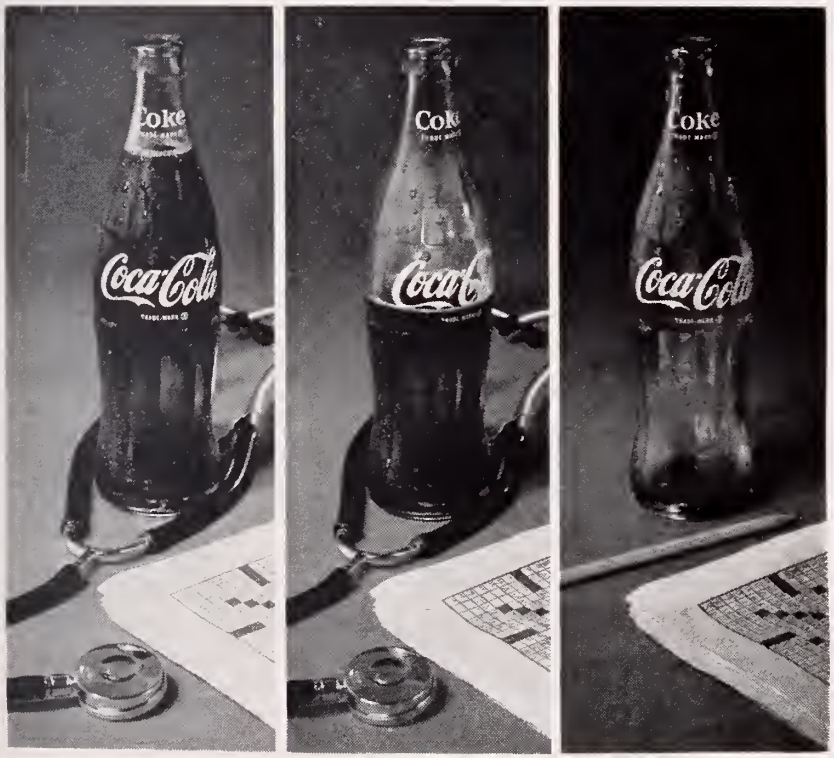
Membership dues allocated to the General Fund as reflected above includes 1966 dues of $5,872.50 collected in December, 1965.

MEDICAL JOURNAL FUND

Statement of Cash Receipts and Disbursements Calendar Year 1965

BALANCE—JANUARY 1, 1965 (Deficit)		($12,324.48)
RECEIPTS		
Advertising	$ 22,085.76	
Emblems sold	35.75	
Subscriptions	249.50	
Refunds	20.00	
Dues (allocated to Journal Fund)—see footnote	4,452.00	
Total Receipts		26,843.01
		14,518.53
DISBURSEMENTS		
Printing	22,031.60	
Engraving	829.71	
Postage	1,313.90	
Salaries and editing	6,362.93	
Travel expense	149.81	
Miscellaneous	524.43	
Total Disbursements		31,212.38
BALANCE—DECEMBER 31, 1965 (Deficit)		($ 16,693.85)
Due General Fund	(10,893.35)	
Due Convention Fund	(3,931.41)	
Due Medical Scholarship Fund	(1,869.09)	
Fund Balance	($16,693.85)	

Membership dues allocated to the Medical Journal Fund as reflected above includes 1966 dues of $304.50 collected in December, 1965.



11:47 pm 11:53 pm 12:06 am

The meaningful pause. The energy it gives. The bright little lift. Coca-Cola with its never too sweet taste, refreshes best. Helps people meet the stress of the busy hours. This is why we say things go better with Coke

TRADE MARK

CONVENTION FUND

Statement of Cash Receipts and Disbursements
Calendar Year 1965

BALANCE—JANUARY 1, 1965		$ 3,763.97
RECEIPTS		
Exhibit space sold	$ 7,302.50	
Dues (allocated to Convention Fund)—see footnote	3,816.00	
Refunds: Convention Golf Tournament	170.00	
Refunds: Expense of speakers	137.44	
Total Receipts		11,425.94
		15,189.91
DISBURSEMENTS		
Supplies and labor	6,187.94	
Travel	819.10	
Expense of speakers	3,039.96	
Advance Convention Golf Tournament	250.00	
Reporting	269.00	
Miscellaneous	442.50	
Auxiliary Convention expense	250.00	
Total Disbursements		11,258.50
BALANCE—DECEMBER 31, 1965		$ 3,931.41
Due from Medical Journal Fund	$ 3,931.41	

Membership dues allocated to the Convention Fund as reflected above includes 1966 dues of $261.00 collected in December, 1965.

AMERICAN MEDICAL ASSOCIATION DUES

Statement of Cash Receipts and Disbursements
Calendar Year 1965

BALANCE—JANUARY 1, 1965	$ None
RECEIPTS	
Dues collected for A.M.A.	55,620.00
	55,620.00
DISBURSEMENTS	
Dues forwarded to A.M.A.	55,620.00
BALANCE DUE A.M.A.—DECEMBER 31, 1965	$ None

PUBLIC SERVICE FUND

Statement of Cash Receipts and Disbursements
Calendar Year 1965

BALANCE STATE ASSESSMENTS—JANUARY 1, 1965 (Deficit)	($ 752.29)
RECEIPTS	
Assessments	None
	(752.29)
DISBURSEMENTS	
Conference and general expense	878.33
BALANCE STATE ASSESSMENTS—DECEMBER 31, 1965 (Deficit)	($ 1,630.62)
Due General Fund	($ 1,630.62)

Now! Unobstructed vision combined with brilliant distal illumination

WELCH ALLYN

No. 330 Fiber Optics Proctological Set, $107.50

Includes No. 322 Sigmoidoscope (19 mm x 25 cm), No. 732 Light Handle with cord, No. 733 Transformer with 6' cord, No. 302 Inflation Bulb.

Other sets available with 15 cm proctoscope or 35 cm sigmoidoscope.

U.S. PATENT NO. 3146775

Welch Allyn's New

FIBER OPTICS

Procto-Sigmoidoscopes

- Fiber optics light transmission eliminates light carriers—permits unobstructed vision.
- Stainless steel construction throughout.
- Brilliant distal illumination is shadow-free, without color distortion.
- Air-tight, securely hinged, non-fogging window.

Light is transmitted from an external source in the handle through approximately 7,000 optical glass fibers encased between the walls of the stainless steel speculum. Feces cannot obscure illumination. There are no delicate or protruding light carriers.

Obturators and specula are interchangeable. The No. 19 lamp can be replaced in seconds during examination without withdrawing the speculum. The entire instrument may be cleaned with most standard germicidal solutions or by gas sterilization.

Ask us to demonstrate how these new fiber optics procto-sigmoidoscopes simplify examination and treatment.

HOSPITAL & PHYSICIANS SUPPLY CO.

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TELEPHONE 344-3554

MEDICAL SCHOLARSHIP FUND

Statement of Cash Receipts and Disbursements Calendar Year 1965

BALANCE—JANUARY 1, 1965		$ 22,439.80
RECEIPTS		
Dues (allocated to Medical Scholarship Fund)—see footnote	$ 7,632.00	
Contributions	535.00	
Interest on U. S. Treasury Bonds	175.00	
Interest on Savings Account	267.63	
Repayments of scholarships	100.00	
Total Receipts		8,709.63
		31,149.43
DISBURSEMENTS		
Scholarship installment	8,000.00	
Travel, printing and miscellaneous expense	76.48	
Total Disbursements		8,076.48
BALANCE—DECEMBER 31, 1965		$ 23,072.95
Balance in Savings Account	6,892.12	
Balance in General Fund Checking Account	14,311.74	
Due from Medical Journal Fund	1,869.09	
Fund Balance	$ 23,072.95	

Membership dues allocated to the Medical Scholarship Fund as reflected above includes 1966 dues of $522.00 collected in December, 1965.

SCHEDULE OF BONDS OWNED AS OF DECEMBER 31, 1965

	Serial	Due Date	Maturity Value
U. S. Treasury 2½%	27846F	12-15-67/72	$10,000.00
U. S. Treasury 2½%	70011A	12-15-67/72	1,000.00
U. S. Treasury 2½%	70012B	12-15-67/72	1,000.00
U. S. Treasury 2½% (Medical Scholarship Fund)	72361A	12-15-67/72	1,000.00
U. S. Treasury 2½%	22646F	12-15-67/72	500.00
U. S. Treasury 2½% (Medical Scholarship Fund)	6873C	9-15-67/72	5,000.00
U. S. Treasury 2½% (Medical Scholarship Fund)	18939K	9-15-67/72	1,000.00
Series "J"	Q22297J	1- 1-1968	25.00
Series "J"	Q22298J	1- 1-1968	25.00
Total			$19,550.00

COMPARATIVE SCHEDULE OF FUND BALANCES AND BONDS AS OF DECEMBER 31, 1964 AND 1965

FUND BALANCES	12-31-64	12-31-65	Increase (Decrease)
General Fund	$12,000.08	$12,523.97	$ 523.89
Medical Journal Fund (deficit)	(12,324.48)	(16,693.85)	(4,369.37)
Convention Fund	3,763.97	3,931.41	167.44
A. M. A. Dues	—	—	—
Public Service Fund (deficit)	(752.29)	(1,630.62)	(878.33)
Medical Scholarship Fund	22,439.80	23,072.95	633.15
Total Fund Balances	25,127.08	21,203.86	(3,923.22)
U. S. BONDS (at cost)	18,621.92	18,621.92	—
TOTAL FUND BALANCES AND BONDS	$43,749.00	$39,825.78	($ 3,923.22)

Need a New Auto Emblem?

A supply of auto emblems, bearing the insignia of the West Virginia State Medical Association, is kept on hand at all times at the headquarters offices in Charleston. The price of each emblem is $3.25 postpaid.

HARDING HOSPITAL, INC.

(Formerly Harding Sanitarium)

WORTHINGTON
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For the Diagnosis and Treatment of Psychiatric Disorders

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Limited Facilities for the Aging

GEORGE T. HARDING, M. D.
Medical Director

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Obituaries

FITZHUGH LEE BANKS, M. D.

Dr. F. L. Banks, 80, of Beckley, died February 27 in a hospital in Richmond, Virginia.

Doctor Banks was born at Madison, Virginia, attended Randolph Macon Academy and received his M. D. degree in 1909 from the Medical College of Virginia. In 1916, he established his practice in Beckley, where he became an eye, ear, nose and throat specialist.

He was an honorary member of the Raleigh County Medical Society, the West Virginia State Medical Association and the American Medical Association. At one time he was President of the Piedmont Medical Society in Virginia.

Survivors include the widow, Mrs. Mary Smith Banks; one daughter, Mrs. Dwight File of Richmond; two sons, William Smith Banks of Alexandria, Virginia, and Mac Ray Banks of Washington, D. C.; six grandchildren and two great grandchildren.

* * * *

EUGENE SCOTT BROWN, M. D.

Dr. Eugene S. Brown, 59, a former three-term Mayor of Summersville, died February 20 in Los Angeles, California.

Doctor Brown practiced in Summersville until failing health forced him to retire to California in 1963. He made his home at Altadena, California.

A native of Beaver, West Virginia, Doctor Brown received his B. S. degree from West Virginia University in 1928 and his M. D. degree in 1930 from the University of Maryland School of Medicine. He served his internship at University Hospital in Baltimore.

He was Secretary-Treasurer of the Central West Virginia Medical Society in 1934 and also was an honorary member of the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow, Louise, of California; a son, Eugene, Jr., of California; daughters, Mrs. Robert Weaver and Mrs. Phillip Eckman of California; the mother, Mrs. Flavius H. Brown of Summersville; brothers, Dr. J. Dudley and Dr. Robert R. of Romney, Dr. J. Morrison of Shinnston, Dr. Flavius H., Jr., of Summersville, Dr. Paul H. of Alderson, and Dr. William H. of Sutton; sisters, Mrs. Robert Jacobson of Marlinton and Mrs. William Juergens of Sutton; and two grandchildren.

* * * *

CLAUDE LACY HOUCK, M. D.

Dr. Claude L. Houck of Lewisburg died February 28 at a hospital in Clifton Forge, Virginia. He was 52.

Doctor Houck was a native of Lewisburg and attended Greenbrier Military School. He received his B. S. degree from West Virginia University in 1935 and his M. D. degree two years later from the Medical College of Virginia. During World War II, Doctor Houck served as an officer in the Medical Corps of the United States Army.

Doctor Houck was a member of the Greenbrier Valley Medical Society, of which he was Vice President; the West Virginia State Medical Association and the American Medical Association.

Survivors include a sister, Mrs. Eloise Wallace of Clintonville; and two brothers, Dr. Marvin R. Houck of Carbon, Kanawha County, and Dr. Charles Houck of Canton, Ohio.

* * * *

ROBERT BARBER PRICE, M. D.

Dr. Robert B. Price, 69, of Charleston, died in a hospital in that city on March 1 after suffering a heart attack.

Doctor Price was born in Charleston and attended Haverford College in Pennsylvania. He received his M. D. degree in 1922 from the University of Pennsylvania School of Medicine.

He interned at Philadelphia Presbyterian Hospital and also had been associated with hospitals in New York City and Washington. He was a past president of the staff of St. Francis Hospital in Charleston.

Doctor Price was a member of the Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow, Mrs. Ruth McCabe Price; a daughter, Mrs. Wayne E. Powell of Charleston; and a son, Robert B. Price, Jr., of Charleston.

Commerce Dept. Releases Figures On Health Care Spending

Americans are increasing their spending for health care. But they still spend more for tobacco than for hospital care, and more for cosmetics and haircuts than for doctor bills, reports *The AMA News*, published by the American Medical Association.

Spending for health care totaled $25.2 billion in 1964, according to figures of the U. S. Department of Commerce. That's an increase of 7.8 per cent from the $23.4 billion spent in 1963.

Hospitals receive the largest share of health-care spending—about 30 cents of every dollar. The total spent for hospital care in 1964 was $7.6 billion. This compares with $7.8 billion spent on tobacco products. Other portions of the health-care dollar are divided among drugs, 17 cents; dentists, 10 cents; health insurance, 7 cents; appliances, 4 cents, and miscellaneous expenses, 5 cents (See chart on Page 98).

The remaining 27 cents goes to physicians. This percentage has declined slightly over the years. Twenty years ago, physicians received about 28 cents of every dollar spent on health care. Expenditures for physicians' services totaled $6.8 billion in 1964, compared to $7 billion spent on personal items such as cosmetics, haircuts, and toiletries.

This was the distribution of the health-care dollar 10 years earlier: hospitals, 24 cents; physicians, 28 cents; drugs, 18 cents; dentists, 12 cents; health insurance, 8 cents; appliances, 5 cents, and other services, 5 cents.

GROUP INSURANCE

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WEST VIRGINIA STATE MEDICAL ASSOCIATION

Sound Protection at a Substantial Saving

OFFICE OVERHEAD EXPENSE INSURANCE

Premiums paid for this policy are Tax Deductible

The practical necessity of keeping your office open when you are "off" because of sickness or injury is an accepted fact—it is also a serious drain on your bank account.

Office Overhead Insurance reimburses you up to 100% of your office expense while you are totally disabled from sickness or injury—the premium you pay for this policy is tax deductible.

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County Societies

CABELL

Mr. Clayton Scroggins, a professional business consultant from Cincinnati, was guest speaker at the regular monthly meeting of the Cabell County Medical Society which was held at the Hotel Frederick in Huntington on February 10.

Mr. Scroggins' topic was "A Management Consultant's Objective Counsel to the Doctor's Problems." He stressed the need for the physician to make the most efficient use of his time, to delegate authority, to surround himself with good office equipment and personnel, and to use careful fee and collection policies.

The Society adopted a resolution supporting the action of the Council of the West Virginia State Medical Association which called for a feasibility survey of a new two-year medical school.

Dr. Joseph R. Bowling was elected to Associate Membership.

Forty-eight members of the Society attended the meeting.—Harold N. Kagan, M. D., Secretary.

HARRISON

Two members of the faculty of the West Virginia University School of Medicine were guest speakers at the regular monthly meeting of the Harrison County Medical Society, which was held at the Stonewall Jackson Hotel in Clarksburg on February 3.

The speakers were Dr. Alphonse C. Edmundowicz, Assistant Professor of Medicine, and Dr. Thomas J. Tarnay, Assistant Professor of Surgery. They gave an interesting presentation on the medical and surgical aspects of thrombophlebitis.

More than 30 members and guests attended the meeting.—Paul E. Gordon, M. D., Secretary.

* * * *

MONONGALIA

Dr. Robert Schein of Pittsburgh was guest speaker at the regular monthly meeting of the Monongalia County Medical Society which was held on February 1.

Doctor Schein gave a talk on "Hospital Utilization Committee." He made these points: that the initial organization of the utilization committee is of utmost importance and that each hospital has its own problems and the committee should conform to these problems.

The Society went on record as opposing a proposal that all past presidents of the West Virginia State Medical Association be named life-time members of the Association's House of Delegates.—Robert Greco, M. D., Secretary.

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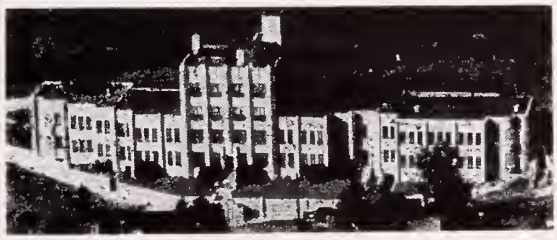
The Institute based its report on data recently released by the United States Department of Health, Education and Welfare, and the Health Insurance Association of America.

HEW found that of the $24.8 billion paid out by the public in 1964 for health services and supplies, $7.6 billion went for hospital care, $6.8 billion for physician services, and the balance went for dentistry, drugs, appliances and other health care needs.

The Institute said that though these monies were expended by both insured and non-insured persons, insurance payments nonetheless met 69 per cent of the total hospital bills and 38 per cent of the doctor bills in 1964. These insurance benefits were received under health insurance policies provided by insurance companies, Blue Cross, Blue Shield, and other health care plans.

Fourteen years earlier—in 1950—comparable figures were 35 per cent of the hospital care costs, half the 1964 proportion, and 12 per cent for physician costs, less than one-third the 1964 proportion.



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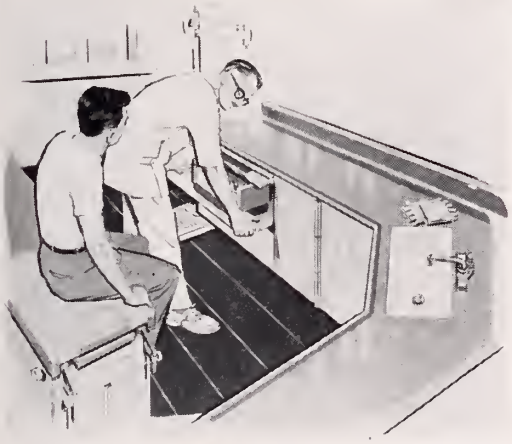

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SPRING BOARD MEETING OF AUXILIARY IN WEIRTON, APRIL 26-27

The Spring Board meeting of the Woman's Auxiliary to the West Virginia State Medical Association will be held in Weirton, April 26-27.

Mrs. Wilson P. Smith of Huntington, the President, urged all Presidents Elect to attend inasmuch as there will be a special workshop for them. Mrs. Hu C. Myers of Philippi, the President Elect, will preside at the special workshop session.

Mrs. Myer Bogarad of Weirton is Chairman of Arrangements for the meeting. She is being assisted by Mrs. Edward A. Gretchen of Weirton, President of the Woman's Auxiliary to the Hancock County Medical Society.

Complete details will be sent to all state officers and county presidents.

Dr. Myer Bogarad is planning golfing for husbands who accompany their wives.

* * * *

KANAWHA

Dr. Richard Kitching, a Charleston psychiatrist, was the guest speaker at the February luncheon meeting of the Woman's Auxiliary to the Kanawha Medical Society in Charleston.

Doctor Kitching said the patient complaining of fatigue is likely a victim of what he termed "trackus rodentia" or "the rat race." Eighty per cent of the causes of fatigue, he said, are not organic.

The Auxiliary voted to donate money it had raised to these projects: Morris Harvey School of Nursing, $900; hearing testing program in the public schools, $500; state health careers, $100; Camp Galahad, $25; and AMA-ERF, $246.74.

Members of the Auxiliary to the Kanawha County Medical Society put aside more serious projects at their March meeting to enjoy a formal fashion show spiced with some hijinks of their own.

The serious part was under the direction of Mrs. R. Thomas Linger.

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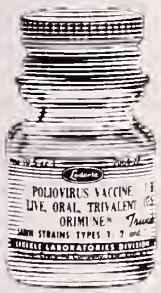

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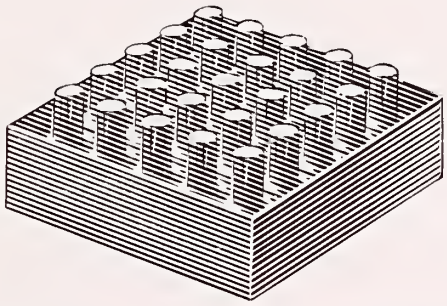

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*Rosenthal, S. R., Nikurs, L., Yordy, E., and Williams, W.: Scientific Exhibit Presented at the Annual Meeting of the National Tuberculosis Association, Chicago, Illinois, May 30-June 2, 1965.

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WOMAN'S AUXILIARY—(Continued)

The fun side of the show was headed by Mrs. Joseph Skaggs and was based on the favorite hobbies of husbands.

Mrs. J. A. B. Holt made her official visit as vice president of the Southern Region of the Auxiliary to the West Virginia State Medical Association.—Mrs. J. L. Mangus, Publicity Chairman.

* * * *

LOGAN

A luncheon meeting of the Woman's Auxiliary to the Logan County Medical Society was held February 23 at the Smoke House in Logan.

Thirteen members attended the meeting. They decided to have the annual Doctors' Day observance at the home of Dr. and Mrs. E. R. Chillag at Holden on April 17.

After the business meeting, the group toured the Logan County Health Department quarters in the new Court House.—Mrs. E. H. Starcher, Publicity Chairman.

* * * *

MINGO

Mrs. Wilson P. Smith of Huntington, President of the Woman's Auxiliary to the West Virginia State Medical Association, was a guest at a silver tea sponsored by the Woman's Auxiliary to the Mingo County Medical Society on February 24.

The Tea was held at the home of Mrs. J. E. Johnson in South Williamson. Proceeds were turned over to AMA-ERF.

Receiving guests as they arrived were Mrs. Johnson and Mrs. L. L. Swigart, President of the county Auxiliary.

More than 200 women attended the tea. Other out-of-town guests in addition to Mrs. Smith included: Mrs. M. Bruce Martin of Huntington, State AMA-ERF Chairman; and Mrs. Ray Kessel of Logan, a Vice President of the Woman's Auxiliary to the West Virginia State Medical Association.

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Book Reviews

THE APPALACHIANS.—By Maurice Brooks. Houghton Mifflin Company, Boston. 1965.

This 350-page book by a well-known West Virginian, often called Doctor Appalachia, who is Professor of Wild Life at West Virginia University, is a delightful change from medical texts and magazines. To know the Appalachian Hills in even a small part is to love them and you couldn't find a better conductor than Maurice Brooks to give you the full treatment from Canada to Alabama.

If vou are young and can hit the trail anywhere from Maine to Georgia you will find it a naturalist's paradise. If you need conveyance, the Skyway Drive and the Blue Ridge Parkway are delightful most of the year. Many of the interesting spots described in the book are in West Virginia and can be reached by state or forest road in one-half a day.

Whether your interest is geography or geology, flora or fauna, you will find much to interest you, almost in your own backyard. There is an excellent index to guide you to any place throughout the 2,000 miles of this vast wonderland.

Have no misgivings, the book has no concern with the Great Society's medical benevolence for Appalachia.

A SYNOPSIS OF CONTEMPORARY PSYCHIATRY—By George A. Ulett, M. D., Professor and Chairman, Department of Psychiatry at the Missouri Institute of Psychiatry, St. Louis, University of Missouri School of Medicine; and D. Wells Goodrich, M. D., Chief, Child Research Branch, National Institute of Mental Health, United States Public Health Service, Bethesda, Maryland. Pp. 299. The C. V. Mosby Company, St. Louis. 1965, Third Edition. Price $6.75.

As far as synopses are concerned, this is a good one. Of course, it has the usual disadvantages of a synopsis —by necessity it treats all the subjects it covers too briefly and too mechanically. It does fulfill the purpose for which it was written: "to fill the need for a brief, introductory text of psychiatry as a quick reference for psychiatric residents, medical and psychological interns, medical students, nurses, and others whose work in the psychiatric clinic and hospital may be for a brief period of time."

The reviewer recommends it for the general practitioner and the specialist as long as a general text of psychiatry is on his bookshelf too.—David H. Smith, M. D.

Change of Address

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Mr. William H. Lively
Executive Secretary
West Virginia State Medical
Association
401 Atlas Building
Charleston, West Virginia 25324

Dear Bill:

Thank you for your response to my recent letter concerning the record-keeping requirements of physicians under P.L. 89-74.

As you remember, my letter of January 7 quoted the following provision of the proposed Food and Drug Administration regulations regarding physician record-keeping requirements; ". . . [the] maintaining of small supplies of these drugs for dispensing or administering in the course of professional practice in emergency or special situations will not be considered as regularly engaged in dispensing for a fee."

The regulations as finally promulgated on January 27 contained examples of fact situations in which the above provision would apply. Emergency or special situation dispensings include dispensings "as a stopgap measure to tide patients over until a regular supply of drugs can be obtained by prescription from a pharmacy, or dispensings as trial doses to patients . . ." These are, of course, instances in which a physician will not be considered to be regularly dispensing. It should be noted in addition that under the wording of the statute even when a physician does regularly dispense, he need not maintain records unless he, in some way, charges for the drug.

Best personal regards,

(s) C. JOSEPH STETLER,
President

Where New Drugs Come From?

Few, if any, new drugs or inventions have been commercially developed in countries which do not offer proper patent protection to the inventor. Of the new drugs introduced in the United States from 1941 to 1964, 369 came from the United States, 44 from Switzerland, 33 from Germany, and 28 from the United Kingdom.

Equally significant is that 90 per cent of the 369 new drugs originating in the United States came from company laboratories.—Michigan Medicine.

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MAY
1966

Vol. 62 No. 5

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Member 1966

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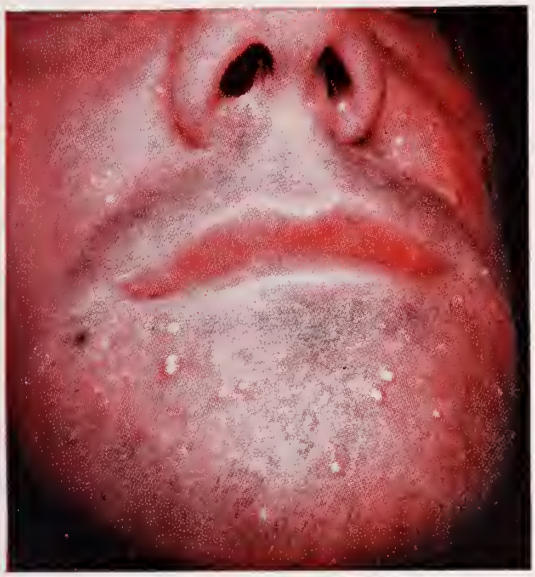

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—News—

THE School of Medicine has accepted 60 students for its 1966 entering class. Dean Clark K. Sleeth said the students—55 from West Virginia, four from Pennsylvania and one from Maryland—were selected by an eight-member faculty committee from among 302 applicants.

In their undergraduate work, the 60 students averaged 3.2 credit points, which is better than a "B" average. Doctor Sleeth also said the group did considerably better on the nationwide Medical College Admissions Test than the national average.

Thirty-three West Virginia communities will be represented in the new class, with Charleston and Huntington contributing seven students each.

The breakdown by communities is as follows:

Charleston: Bernard Hirsch, Roy R. Kinder, Jr., James M. Previll, Frederick S. Raines, Roland J. Weisser, Jr., Robert A. Woolfitt and Sandra S. Woolfitt.

Huntington: Homer L. Christian, Robert R. Dennison, Jr., Herman L. Leap, Frank C. Riggall, Terrence R. Steiner, Ronald L. Weed, Jr., and James J. Wellman.

Morgantown: Thomas W. Crosby, Ralph L. Greene, Jr., John T. Gwynne, Linda A. Long, Joseph D. Ruffner, and Orlando C. Snead, III.

South Charleston: Leon A. Dickerson, Jr., and Susan T. Luzader.

Ravenswood: William A. Brownlee and James M. Stevenson.

Wellsburg: Robert B. Noland and Kathleen M. Vincent.

Bridgeport: Charles R. Loar and Jeffry L. Marks.

Fairmont: John L. Lockhart and John E. Van Gilder.

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Kenton E. Harris, Gassaway; Ray L. Henderson, Logan; William R. Hobbs, Chester; Hartmut L. Huber, Montgomery; John N. Hutzler, Jr., Martinsburg; Louis V. Kaufman, Moundsville; William F. Kellermeyer, Jr., Wheeling; David P. Lee, Nitro, John A. Mathias, Jr., Moorefield.

Roger L. McCauley, Belington; Michael A. Morehead, Parkersburg; Robert E. Roy, Matewan; Charles E. Snyder, Asbury; Lawrence B. Thrush, Jr., Clarksburg; James M. Wade, Princeton; John B. Walden, West Hamlin; David K. Walker, St. Albans.

• **Compiled from material furnished by Arthur V. Ciervo, Director, Medical Center News and Information Services, Morgantown, West Virginia.**

Out-of-state students accepted are:

Pennsylvania: Robert B. Friedman, Monroeville; Robert C. Heslop, Jr., McKeesport; Gary J. Marcus, Bethlehem; and David J. Withersty, Sharon.

Maryland: David G. Lewis, Cumberland.

Quick Freeze Operation

A quick-freeze operation for prostate trouble is being performed at West Virginia University Hospital.

Dr. D. Franklin Milam, Professor of Urology and Surgery, said the Medical Center is one of several institutions in this country chosen to test the new procedure.

The technique offers a scalpel-free operation on the prostate. The complete procedure, according to Doctor Milam, takes about 15 or 20 minutes, and there is no bleeding. Postoperative hospital stay amounts to about one week.

Drs. Marshall and Darby Write Book

Drs. Robert J. Marshall and Thomas D. Darby are authors of a new book entitled, "Shock: Pharmacological Principles in Treatment."

The book, published by Charles C. Thomas of Springfield, Illinois, is based on the personal experiences the authors have had with cases of shock at the WVU Medical Center and elsewhere, and on a review of the literature.

Doctor Marshall is Professor of Medicine and Chairman of the Division of Cardiology at the WVU School of Medicine. Doctor Darby, a former member of the faculty of WVU's Department of Pharmacology, is now a pharmacologist for Abbott Laboratories.

Cancer Research Seminar

The last in a series of nine cancer research seminars will be held Tuesday, May 17, in Room 4080 beginning at 7:30 P.M.

The session will feature a lecture by Dr. Dean R. Goplerud, Assistant Professor of Obstetrics and Gynecology in the School of Medicine. His topic will be "Enzyme Studies in Female Genital Cancer Detection."

Visiting Lecturer

Dr Thomas B. Barnett, Professor of Medicine at the University of North Carolina, will be at WVU on Friday, May 6, as visiting professor of pulmonary diseases.

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Warning — In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of discomfort.

Precautions and Side Effects — Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncracy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg of demethylchlortetracycline HCl.

Tablets: film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

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The Month in Washington

• From the Washington Office of the American Medical Association.

THE Johnson administration wants to prohibit manufacturers from mailing physicians free prescription drug samples except when specifically requested. The administration also has proposed that door-to-door distribution of samples of over-the-counter drugs also would be banned.

The proposals are included in new drug legislation that would expand the authority and responsibilities of the Food and Drug Administration in policing drugs.

The legislation would have Congress find that:

(1) The mass of unsolicited samples of prescription drugs supplied to licensed practitioners by manufacturers and distributors through the mails and otherwise has led to large-scale discarding and other disposal of unwanted samples which are finding their way into the hands of persons who scavenge and repack such drugs and sell them to pharmacists for dispensing on prescription in the same manner as regular stock of drugs;

(2) Children have obtained carelessly discarded samples;

(3) The dispensing or sale of a prescription drug sample to a patient for a fee without identification of the drug as a sample is a deceptive practice; and

(4) The unsolicited distribution of nonprescription sample drugs directly to householders lacks minimum safeguards which would be involved in the sale of the drug in a pharmacy or other place of business.

Labels would have to read "SAMPLE DRUG. FEDERAL LAW PROHIBITS ANY CHARGE OR FEE FOR THIS DRUG."

Under the legislation, the FDA would be authorized to require records and reports of adverse reactions and efficacy on all drugs now being marketed. Dr. James L. Goddard, Food and Drug Administration Commissioner, already had ordered a review of drugs cleared before 1962.

Another provision of the legislation would "require certification of all drugs whose potency and purity can mean life or death to a patient," thus extending the law which now applies to insulin and antibiotics.

The Pharmaceutical Manufacturers Association expressed doubt that the FDA could carry out such an additional responsibility. PMA President C. Joseph Stetler said it seems "unwise to propose new areas of responsibility for an agency which has not yet proven its ability to administer" its present programs.

Mr. Stetler added:

"The industry has said before that no amount of labeling can protect an individual who refuses to protect himself by ignoring his doctor's orders or the directions on the label of his medicine."

Critical Speech by Doctor Goddard

In a speech highly critical of the ethical drug industry at the annual meeting of the PMA, Doctor Goddard talked of irresponsibility. He said "too many drug manufacturers may well have obscured the prime mission of their industry: to help people get well." He said he had been shocked by the quality of some of the data on new drugs submitted to the FDA. There also "is the problem of dishonesty in the investigational drug stage," he said.

Doctor Goddard further charged that some drug advertisements "have trumpeted results of favorable research and have not mentioned unfavorable research; they have puffed up what was insignificant clinical evidence; they have substituted emotional appeals for scientific ones."

Mr. Stetler said after the speech that he and his colleagues feared the talk "might, unfortunately, be interpreted as an indictment of the entire drug industry, because of its overemphasis on isolated instances, without acknowledging the integrity and responsibility which our industry has consistently demonstrated."

"It is an unassailable fact," Mr. Stetler said, "that the scientific attainments and standards of performance of the American prescription drug industry have provided an immeasurable benefit to the improvement of health and the prolongation of life."

Estimated Cost of Medicare

Officials estimate that the hospitalization part of medicare will cost about $2.3 billion in the first year of the program which starts on July 1.

Benefit payments under Plan B, the medical part of medicare, are estimated at $765 million for the first year. Premium collections—$3 per person per month—are estimated at $550 million, which will be matched by the federal government.

Persons 65 years or older have until May 31 to sign up for Plan B. The original deadline for signing up was March 31. On that date, 1.3 million of the 19.1 million persons 65 or older had not indicated whether they wanted Plan B coverage. About 16.8 million, or 88 per cent, had signed up and one million, or about five per cent, had said they did not want the coverage.

The human spine is not engineered fo prolonged sitting at desks, pianos, type writers and drafting boards. The stresses set up by the heavy, forward-tilted heac and trunk, balanced precariously on ar insufficient base, result in strain of the dorsal musculature, particularly at the low lumbar level.

The unusual muscle-relaxant and analgesic properties of 'Soma' make it espe cially useful in the treatment of low back sprains and strains. 'Soma' is widely prescribed ☐ **to relieve pain** ☐ **to relax muscles** ☐ **to restore mobility.**

Indications: 'Soma' is useful for management o muscle spasm, pain, and stiffness in a variety o inflammatory, traumatic, and degenerative muscu loskeletal conditions. It also may act to normalize motor activity in certain neurologic disturbances

Contraindications: Allergic or idiosyncratic reac tions to carisoprodol.

Precautions: 'Soma', like other central nervous system depressants, should be used with cautior in patients with known propensity for taking ex cessive quantities of drugs and in patients with known sensitivity to compounds of similar chemi cal structure, e.g., meprobamate.

Side Effects: The only side effect reported with any frequency is sleepiness, usually on higher thar recommended doses. An occasional patient may not tolerate carisoprodol because of an individua reaction, such as a sensation of weakness. Othe rarely observed reactions have included dizziness ataxia, tremor, agitation, irritability, headache, in crease in eosinophil count, flushing of face, anc gastrointestinal symptoms.

One instance each of pancytopenia and leuko penia, occurring when carisoprodol was admin istered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodo and subsequent cross reaction to meprobamate Rare allergic reactions, usually mild, have includec one case each of anaphylactoid reaction with milc shock and angioneurotic edema with respirator difficulty, both reversed with appropriate therapy In cases of allergic or hypersensitivity reactions carisoprodol should be discontinued and appropri ate therapy initiated. Suicidal attempts may pro duce coma and/or mild shock and respirator depression.

Dosage: Usual adult dose is one 350 mg. table three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white tablets and 250 mg. orange, two-piece capsules.

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Obituaries

JOHN WEBSTER DUFF, M. D.

Dr. John W. Duff, 93, of Charleston, died at his home on April 4 after a brief illness.

Doctor Duff arrived in Charleston in 1915 after practicing in Jackson County for about five years. He received his M. D. degree in 1910 from the University of Louisville Medical School.

He was a former member of the West Virginia State Medical Association and had served on the Charleston City Council for a number of years.

Survivors include the widow, Mrs. Elizabeth Morgan Duff; daughters, Mrs. Thelma Van Winkle and Mrs. Delta Smith, both of Charleston, and Mrs. Lessie Burdette of Miami, Florida; sons, Eugene Duff of Charleston, Dr. Wirt W. Duff of Elkview, F. O'Dair Duff of Miami, Florida, and Dr. John W. Duff, Jr., of Cocoa, Florida; a sister, Mrs. Sally Hinzman of Dunbar; and a brother, Dr. Rath Duff of Miami, Florida.

* * * *

EDMUND OLIVER GATES, M. D.

Dr. Edmund O. Gates of Welch was found dead March 17 at the foot of some steps leading to his home. Authorities said he apparently suffered fatal injuries in an accidental fall.

Doctor Gates, 60, was born in Howard City, Michigan, and received degrees at Grand Rapids Junior College and Northwestern University before receiving his M. D. degree from Northwestern University Medical School in 1932.

He interned at Cook County and University hospitals in Chicago and later served an eye, ear, nose and throat residency at Cook County and Presbyterian Hospitals.

Doctor Gates was a member of the McDowell County Medical Society, of which he was a former president; the West Virginia State Medical Association, the American Medical Association and the American Academy of Ophthalmology and Otolaryngology. He was certified by the American Board of Ophthalmology.

He began practice in Welch in 1939 and served in World War II as a Lieutenant Colonel in the Medical Corps of the U. S. Army. He returned to Welch after the war.

Doctor Gates is survived by his widow and a daughter, Donna, at home; three children by a previous marriage, Dr. George Gates of Ann Arbor, Michigan, Robert Gates of Los Angeles and Miss Aileen Gates of Chicago; a brother, Cecil Gates of Orchard Lake, Michigan; two sisters, Mrs. Noreen Cameron of Howell, Michigan, and Mrs. Ruth Semrau of East Detroit, Michigan.

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E. C. Voss, M. D.

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W. F. Park, M. D.
M. E. Nugent, M. D.

Orthopedic Surgery:
C. B. Buffington, M. D.
G. B. Krivchenia, M. D.

Thoracic Surgery:
Daniel W. Dickinson, M. D.

Obstetrics and Gynecology:
Robert W. Leibold, M. D.
Robert T. Brandfass, M. D.
Hugh R. Haltrop, M. D.

Urology:
Richard D. Gill, M. D.

Neurological Surgery:
James S. Rogers, M. D.
Frank M. Hudson, M. D.

Internal Medicine
Charles H. Hiles, M. D.
Albert M. Valentine, M. D.
James A. Jacob, Jr., M. D.

Psychiatry and Neurology:
Albert L. Wanner, M. D.
Stephen D. Ward, M. D.
David H. Smith, M. D.

Roentgenology:
William K. Kalbfleisch, M. D.

Clinical Laboratories:
Donna Bryan, M. T.

Technologists:
Electrocardiography:
Patricia Pastor, R. N.
Electroencephalography:
Joann Green, R. N.
June Althar, R. N.
Roentgenology:
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CHESTERFIELD JAMES HOLLEY, M. D.

Dr. C. J. Holley of Bridgeport, Ohio, who practiced in Wheeling for many years, died in a hospital at Martins Ferry, Ohio, on April 3.

A native of Irondale, Ohio, Doctor Holley, 72, was an honorary member of the Ohio County Medical Society, the West Virginia State Medical Association and the American Medical Association.

He attended Kenyon College for two years before receiving his M.D. degree in 1922 from Jefferson Medical College. He interned at Receiving Hospital in Detroit. He was a surgeon specializing in proctology. Doctor Holley leaves his widow, Mrs. Velma Holley; a daughter, Cynthia Jane Holley of London, England; a brother, Dr. E. A. Holley of Martins Ferry; and a granddaughter.

* * * *

JUNIOR WINFRED MYERS, M. D.

Dr. J. W. Myers of Glen Dale, President of the Marshall County Medical Society, died unexpectedly at his home on March 17. He was 52.

A native of Philippi, Doctor Myers attended Alderson-Broaddus and West Virginia Wesleyan colleges and received his M. D. degree in 1937 from the University of Tennessee College of Medicine.

A Fellow of the American College of Surgeons, Doctor Myers specialized in ophthalmology. Other professional memberships included the Southeastern Surgical Congress, the West Virginia State Medical Association and the American Medical Association.

Doctor Myers served his internship at Touro Infirmary in New Orleans. He served an eye, ear, nose and throat residency at Hutchinson Memorial and Charity hospitals in New Orleans and a residency in ophthalmology at Jefferson Davis Hospital in Houston, Texas.

He formerly was Associate Professor at the Tulane and Rice Medical schools and during World War II he served as a Captain in the U. S. Army Air Corps.

Survivors include the widow, Mrs. Virginia Myers; one son, Dr. Joseph W. Myers of Moundsville; five daughters, Mrs. Virginia Murray of Schnectady, New York, Mrs. Suzanne Rossell of Moundsville, Linda Myers of Philippi, Amelia Myers of West Virginia University, and Rebekah Myers of Glen Dale; two brothers, Drs. Karl J. and Hu C. Myers, both of Philippi; and one sister, Dr. Edna Myers Jeffries of Arlington, Virginia.

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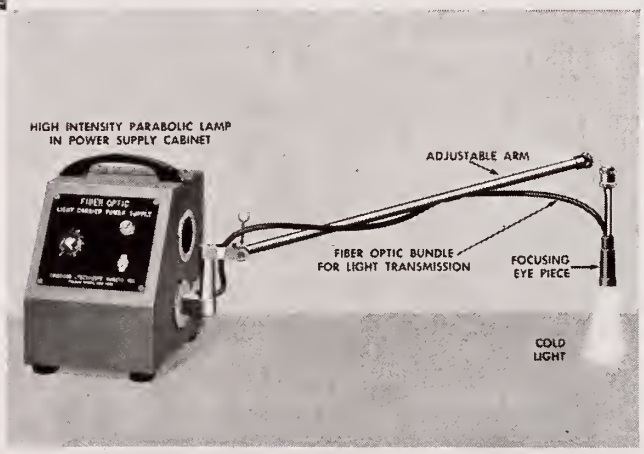

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County Societies

CABELL

The regular monthly meeting of the Cabell County Medical Society was held at the Hotel Frederick in Huntington on March 10.

Dr. Joseph M. Farrell, President of the Society, introduced the guest speakers, Mr. Charlie Snyder, football coach at Marshall University, and Mr. Ellis Johnson, basketball coach. Both gave interesting talks on their athletic programs and the problems they encounter. An active discussion period followed.

The Society elected Dr. Jaldir Lobo to active membership.

Dr. Kirk David, Chairman of the Program Committee, announced that the April meeting would be combined with that of the local bar association.

Fifty-one members and guests attended the meeting. —Harold N. Kagan, M. D., Secretary.

* * * *

HARRISON

Dr. Dee M. Rasmussen of Lexington, Kentucky, was guest speaker at the regular monthly meeting of the Harrison County Medical Society which was held at the Stonewall Jackson Hotel in Clarksburg on April 7.

Doctor Rasmussen, an epidemiologist for the U.S. Public Health Service, gave an interesting talk on "Syphilis, the Modern Diagnosis and Management." He used color slides to illustrate his paper.

Dr. Richard K. Hanifan, the President, presided at a business meeting following the program. About 40 members and guests attended.—Paul E. Gordon, M. D., Secretary.

* * * *

MERCER

Dr. B. B. Richmond of Beckley was guest speaker at a joint meeting of the Mercer and McDowell County Medical Societies which was held at the West Virginian Hotel in Bluefield on March 21.

Doctor Richmond, Medical Director of the Health Insurance Benefits Unit of the State Health Department, discussed Medicare. He said the success of the new program will require the cooperation of all doctors and medical societies.

A motion to endorse the Mercer County cancer, heart disease and stroke project was made and adopted. —John J. Mahood, M. D., Secretary, Mercer County Medical Society.

* * * *

MONONGALIA

Dr. E. F. Heiskell, Jr., of Morgantown, was principal speaker at the regular monthly meeting of the Monongalia County Medical Society which was held on March 1 in Morgantown.

Dr. Philip Sprinkle, Chairman of the Division of Otolaryngology at the West Virginia University School of Medicine, was elected to membership in the Society.

Thirty-four members, 14 medical students and one guest attended the meeting.—Robert Greco, M. D., Secretary.

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Contraindications: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised; especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of pre-existing symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dose—operation of motor vehicles, machinery or other activity requiring alertness should be avoided. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia, the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor, and respiratory collapse.

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AUXILIARY CONVENTION IN CHICAGO

The 43rd Annual Convention of the Woman's Auxiliary to the American Medical Association will be held in Chicago, June 26-30.

Mrs. Richard A. Sutter, National President, and Mrs. Wilson P. Smith, President of the Woman's Auxiliary to the West Virginia State Medical Association, issued a cordial invitation to all West Virginia members to attend. Headquarters will be at the Drake Hotel.

A highlight of the convention will be a reception honoring Mrs. Sutter and the President Elect. Husbands and guests are invited. A program for teenagers also is planned.

The March issue of *M. D.'s Wife* carried a hotel reservation form. Details of the program will be published in the May issue of *M. D.'s Wife* and the June number of *The West Virginia Medical Journal.*

HARRISON

The Woman's Auxiliary to the Harrison County Medical Society held an AMA-ERF benefit bridge at the Clarksburg Y. W. C. A. on March 3.

A salad luncheon was served, and about 20 tables of bridge were in play. Sale of the salad recipes, AMA-ERF playing cards and carolers resulted in a most successful benefit.

Mrs. C. S. Harrison was chairman for the event.

The Harrison County Auxiliary sponsored its "Doctors' Day" party at the Clarksburg Country Club on March 19.

The program included a social hour, dinner and dancing.

St. Patrick's Day decorations, top hats, pixies, large shamrocks and greenery made for colorful table decorations.

The committee in charge of the event was headed by Mrs. Richard V. Lynch, Jr.—Mrs. James E. Wilson, Jr., Publicity Chairman.

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KANAWHA

Mrs. Arthur A. Abplanalp of Charleston was elected President of the Woman's Auxiliary to the Kanawha Medical Society at a tea held at the home of Dr. and Mrs. W. Alva Deardorff in Charleston in April. She succeeds Mrs. James H. Walker.

Other new officers are: Mrs. J. L. Mangus, President Elect; Mesdames Willis D. Garrard, George V. Hamrick, James T. Spencer and Grover B. Swoyer, Vice Presidents; Mrs. David Bachwitt, Recording Secretary; Mrs. Deardorff, Treasurer; and Mrs. Ralph J. Holloway, Corresponding Secretary.—Mrs. J. L. Mangus, Publicity Chairman.

* * * *

LOGAN

The regular monthly meeting of the Woman's Auxiliary to the Logan County Medical Society was held at the home of Dr. and Mrs. Dana T. Moore in Omar on March 30.

Plans were made for the Doctors' Day party, which was to be held at the home of Dr. and Mrs. E. R. Chillag of Holden.

Ten members attended the meeting.—Mrs. E. H. Starcher, Publicity Chairman.

* * * *

MARION

Dr. Seigle W. Parks of Charleston, President of the West Virginia State Medical Association, and Mrs. Parks were among guests of honor at the Doctors' Day observance sponsored by the Woman's Auxiliary to the Marion County Medical Society. The event was held March 30 at the Fairmont Field Club.

The event included a social hour, dinner and dancing.

Other guests included Dr. and Mrs. Hu Myers of Philippi. Mrs. Myers is President Elect of the Woman's Auxiliary to the West Virginia State Medical Association.

Doctor Parks, in brief remarks to the group, spoke on Medicare and other aspects of medicine.

Another feature of the evening was a performance by a quartet called "The Caduceus Quartet," composed of Mesdames William A. Ehrgott, J. J. Jenkins, Jr., E. D. Wise and Philip Johnson. They sang a song of praise to the medical profession composed by Mrs. Johnson and rendered to the tune of "Easter Parade."

* * * *

OHIO

Members of the Woman's Auxiliary to the Ohio County Medical Society honored their husbands with a special Doctors' Day program at the Wheeling Country Club on March 26.

A buffet dinner was served. This was followed by a brief program honoring physicians and dancing.

* * * *

RALEIGH

The Woman's Auxiliary to the Raleigh County Medical Society sponsored a dinner dance at the Black Knight Country Club in Beckley on March 30 in observance of Doctors' Day.

There was a brief period of meditation for deceased members of the Raleigh County Medical Society.

Mrs. Harry F. Cooper was in charge of activities.

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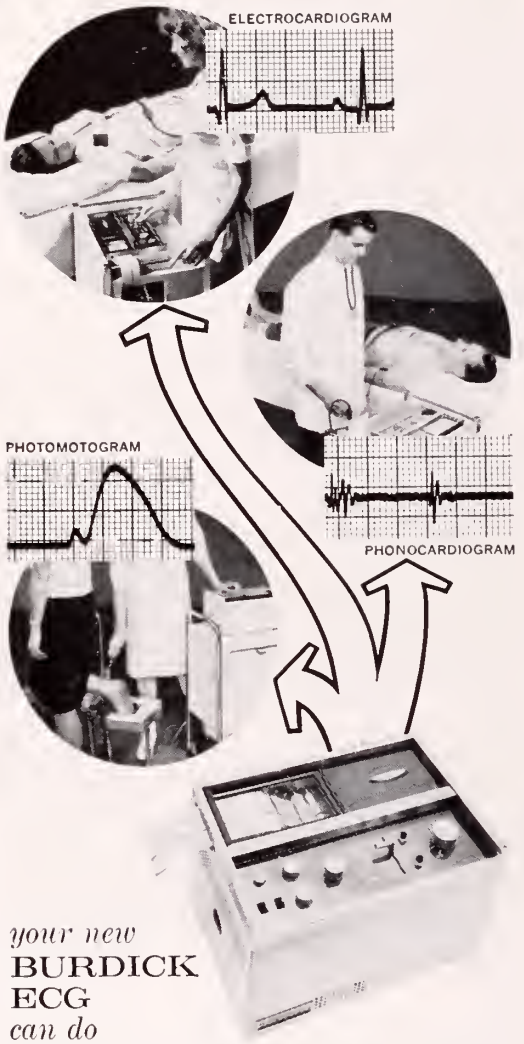

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Book Reviews

CONTROVERSY IN INTERNAL MEDICINE—By Franz J. Ingelfinger, M. D., Professor of Medicine, Boston University School of Medicine; Arnold S. Relman, M. D., Professor of Medicine, Boston University School of Medicine; Maxwell Finland, M. D., Professor of Medicine, Harvard Medical School. W. B. Saunders Company, Philadelphia, London. 1966. Pp. 679. Price: $14.50.

This 600-page book consists of a series of medical debates on various controversial medical problems. The subjects range from atherosclerosis to antibiotics to anticoagulants with extended remarks on board certification and statistical studies.

Each subject has a pro and a con enthusiast and sometimes a third contender is added for good measure. Each presentation is topped off with a comment by a capable referee. So—it is plain that this book is a highly unusual text.

Many of the speakers are nationally known-proponents of their particular argument; for instance—the reader is presented with an authoritative, succinct account of the need for anticoagulants in myocardial infarction. The negative side is presented by Tage Helden of Copenhagen who conducted one of the original studies that indicated a lack of value in this therapy. The commentator is unbiased and remains in a neutral corner.

To those physicians who have taken a positive position on diagnosis and therapy, and haven't reviewed their stand in recent years, the book will be uninteresting. To the many doctors who prefer their medicine delivered in a precise package, the book will be a waste of money and time.

To the many internists and family physicians who choose to while away their leisure with a delightful readable medical book and who wish to be entertained by and interested in all aspects of a particular phase of medicine, this book will occupy top priority for many nights and days. It is a text that most of us will enjoy from cover to cover.

* * * *

THE HEART—Its Function in Health and Disease—By Arthur Selzer, M. D. University of California Press, Berkeley and Los Angeles. 1966. Pp. 301. Illustrated. Price: $5.95.

This book is No. 1 in a series called "Perspectives in Medicine." As stated in the preface it is intended for non-professional serious readers. It also is hoped that the practitioner may find qualified answers to the patients' questions. It is hoped "the book will fill the gap between popular publications and books written for those with a medical background."

The book consists of three parts. The normal heart, the abnormal heart and diseases of the heart and circulation. It has an excellent glossary and a good index.

This book is very attractive and is generally readable, providing the reader has substantial educational background. It is not written in the simple manner of the "medical" best sellers. The illustrations look like those in a standard medical text and may be too advanced for the average lay reader.

The author states that one-eighth of our adult population has some heart disease and another one-eighth is suspected of having heart disease. This is a captive audience of one-fourth of the population who might be sufficiently concerned about their personal problem to become more informed.

The chapter on history is interesting to all. The section on anatomy and physiology may be tough going for many who lack the background for such complexity.

The book will be informative to most patients and a help to many physicians.

* * * *

APPLIED HYPNOSIS AND POSITIVE SUGGESTION—By George A. Ulett, B. A., M. S., M. D., Ph. D., University of Missouri School of Medicine; and Donald B. Peterson, M. D., Superintendent, Fulton State Hospital, Fulton, Missouri. The C. V. Mosby Company, St. Louis. 1965. Pp. 134. Price: $8.50.

This is a very good introductory book for the doctor interested in learning something about hypnosis. It has a light, readable style, scholarly but not dull. The authors make no fantastic claims for hypnosis. They emphasize that hypnosis can be another therapeutic tool useful in some illnesses with selected patients.

There is a brief history of hypnosis. The theories of hypnosis are presented. Induction techniques are described. The value of hypnosis in various specialties, in medicine and in habit control is discussed. There is a biography and index to complete this excellent book.—David H. Smith. M. D.

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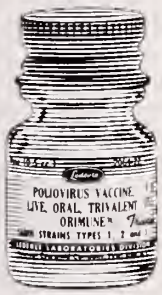

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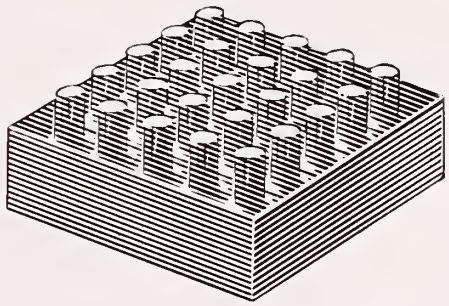

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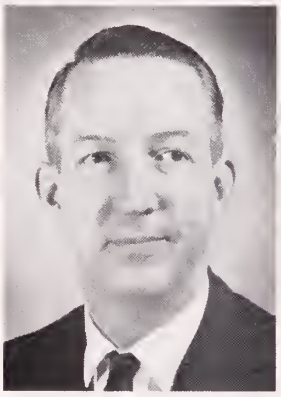
WVU Medical Center
—News—

Dr. David Z. Morgan of Morgantown, Assistant Professor of Medicine at the WVU School of Medicine, has been appointed Assistant Dean of the School.

In announcing the appointment, WVU President Paul A. Miller said Doctor Morgan would continue as Assistant Professor and Medical Director of the Out-patient Department at University Hospital.



David Z. Morgan, M. D.

Dr. Clark K. Sleeth, Dean, said Doctor Morgan's principal duties "are in the areas of student educational affairs and in continuing education for graduates." He will help medical students choose their clinical experiences and internship programs.

A native of Fairmont, Doctor Morgan received his B. S. degree from WVU in 1950 and his M. D. degree from the Medical College of Virginia in 1952. He interned at Ohio Valley General Hospital in Wheeling and served a residency at WVU.

Doctor Morgan served at WVU in 1953-55 first as a physician at the Health Center and then as assistant Professor of Pathology. He was engaged in private practice in Morgantown from 1955 until he rejoined the School of Medicine in 1964.

Doctor Morgan is a Past President of the Monongalia County Medical Society and a member of the West Virginia State Medical Association.

Intern Appointments

Fifty-four medical students, who received their M. D. degrees in May at the West Virginia University School of Medicine, will begin their internship programs on July 1.

Dr. Clark K. Sleeth, Dean of the School, said 46 of the 54 new physicians received their first choices under the National Internship Matching Program. Seventeen of the graduates will intern in West Virginia hospitals, four in military hospitals and 32 at institutions in 14 other states. One student has not decided on his internship.

The list of students, their home towns and places of internship is as follows:

West Virginia University Hospital—Patsy B. Cipolloni, Jr., Masontown; Ethel L. Eschenmann, Clarksburg; Patricia McKay Gregg, Morgantown; Warren R. Pistey, Bridgeport, Connecticut; Robert S. Salisbury, Fairmont; Helge A. Wanger, Shepherdstown; and Arthur N. Ward, Fairmont.

Charleston Memorial Hospital—William R. Fields, Huntington; Samuel L. Henson, St. Albans; and Tony C. Majestro, Kimball.

Ohio Valley General Hospital, Wheeling—Phillip B. Mathias, Mathias; Donald L. Spencer, Franklin, Pennsylvania; and Ronald K. Stupar, Morgantown.

Cabell-Huntington Hospital—William E. Barnes, Grantsville; John E. Beane, Gassaway; Arlo P. Brooks, Jr., Sissonville; and William E. Christian, Jr., Huntington.

Lancaster (Pa.) General Hospital—Thomas C. Amend, Greensburg, Pennsylvania.

Methodist Hospital of Indiana, Indianapolis—James M. Brantly, St. Albans.

Ben Taub General Hospital, Houston, Texas—Michael D. Butcher, Weston; and Elliott L. Thrasher, Sistersville.

Medical College of Virginia Hospital Division, Richmond—John A. Cardea, Welch.

Harrisburg (Pa.) Hospital—James F. Carney, Clarksburg.

University of Rochester Strong Memorial Hospital—Paul M. Chikos, Jr., Logan.

Akron (Ohio) City Hospital—Maritsa P. Cosmides, Wheeling; Randolph L. Pifer, Keyser; Charles E. Ross, Wheeling; Jackie L. Summers, Clarksburg; and James W. Woodford, Philippi.

Philadelphia (Pa.) General Hospital—Harry E. Davis II, Milton.

San Diego (Calif.) County General Hospital—Sanford B. Diznoff, Charleston.

U. S. Naval Hospital, Portsmouth, Va.—John B. Dorsey, Beckley; and Charles H. Mann, Princeton.

Charity Hospital of Louisiana, New Orleans—John H. Ellyson, Morgantown; and Larry T. Schwab, Kingwood.

Presbyterian-University Hospital—Pittsburgh—Donald D. Glass, Lancaster, Pennsylvania.

Mound Park Hospital, St. Petersburg, Fla.—Charles E. Haislip, Grafton; Michael W. Montgomery, Keyser.

Memorial Hospital, Chapel Hill, N. C.—James B. Hammond, Morgantown.

(Continued on Page xl)

• **Compiled from material furnished by Arthur V. Ciervo, Director, Medical Center News and Information Services, Morgantown, West Virginia.**

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Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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The Month in Washington

• **From the Washington Office of the American Medical Association.**

THE importance of the role of the general practitioner is emphasized in the recommendations of the National Commission on Community Health Services to President Johnson. The Commission said that everyone should have a personal physician, even under the group practice system. Under these conditions, the commission added, group practice should be stimulated. It is essential that the physician-patient relationship be strengthened "if comprehensive personal health services of high quality for each individual are to be achieved," the commission said.

"The long range import of the recommendation of having the personal physician assume responsibility as the central source for preventive health service and continuing care, most particularly its impact on medical education, is well appreciated.

"The possibility of attracting a sufficiently large number of medical graduates to careers as personal physicians presupposes a general recognition of the importance of the role and commensurate rewards in professional satisfaction and income comparable to that of other physicians. In all its ramifications, the national effort must be comparable in magnitude to that which expanded medical research personnel in the last two decades. Large scale financing will be necessary for the support of teachers, students, facilities, programs and educational research."

Evaluation of Drugs

The National Academy of Sciences-National Research Council will undertake for the Food and Drug Administration a new evaluation of the efficacy of about 4,000 prescription drugs, starting this summer.

"The determination of the efficacy of new drugs marketed from 1938 to 1962 is called for under the Kefauver-Harris Amendments of 1962," Dr. James L. Goddard, FDA Commissioner said.

The review will be the most extensive efficacy study of drugs ever undertaken, Goddard said. Results of the study will guide the FDA in its final determination of the effectiveness of the drugs.

C. Joseph Stetler, president of the Pharmaceutical Manufacturers Association, commended the selection of the academy for the task.

"PMA is delighted that this method was selected," Mr. Stetler said. "Based on past activities, we are certain that the academy will work with both industry and medical practitioners in forming guidelines for determining the effectiveness of these products."

"Although this undertaking will be of extraordinary magnitude for an Academy-Research Council advisory study, it is also one of extraordinary importance to the medical profession and the nation," Dr. Frederick Seitz, NAS-NRC president said. "It is essential that the study have the strongest possible professional base; we shall, therefore, depend on the cooperation, not only of many individual medical scientists, but also of the major professional societies interested in therapeutic drugs."

Since October, 1962, manufacturers have been required under the Kefauver-Harris Amendments to submit substantial evidence to support therapeutic claims before receiving FDA approval to market a new drug. The NAS-NRC review will put to the efficacy test new drugs marketed under the provisions of 1938 legislation, which required only a showing that drugs were safe for their intended use. The 1938 Act excluded from FDA approval procedures drugs already on the market, as well as drugs introduced after that date that were generally recognized as safe by qualified experts.

Dr. James Z. Appel, President of the American Medical Association, sharply criticized the FDA's enforcement of the 1962 Drug Act Amendments in a speech at Chicago.

"The manner in which the Agency suddenly seizes drugs and accompanies this activity with alarming language tends to create an atmosphere of hysteria," Doctor Appel said. "It also is creating a restrictive and undesirable medico-legal climate that will inevitably exert a deleterious influence on the effective use of drugs by the physician. This trend is causing the medical profession much concern. . . .

"Nagging us is the increasing suspicion that regulatory decision may be dictated more by the technicalities of regulatory language than by appeal to competent medical and scientific analysis and judgment. The tame submission of the pharmaceutical industry to any and every regulatory suggestion or directive, regardless of the medical and scientific facts involved, is unsettling. . . .

"At the time of the passage of the 1962 amendments and subsequent regulations, we were concerned about the advisability of non-medically oriented lay FDA inspectors being permitted to inspect and copy the case records of physicians engaged in clinical investigation. This could only result in a non-professional acting as a judge in a professional area and also invading the physician-patient relationship. We have been apprised of incidents where such inspection has extended even to the personal file of an investigating physician. The future implementing of this aspect of drug investigation cannot help but concern us."

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Obituaries

HENRY REESE GLASS, M. D.

Dr. Henry R. Glass of Charleston died in a Charleston hospital on May 12. He was 69.

Doctor Glass attended Morris Harvey College and Marshall University and received his M. D. degree in 1923 from the University of Louisville. He was a founder of Mountain State Hospital in Charleston, was a former member of the Kanawha County Board of Education and had served as team physician for several football squads in the county school system.

Doctor Glass, whose specialty was surgery, was a Fellow of the American College of Surgeons. He was a member of the Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association.

In 1943, he was awarded an honorary doctorate degree by Morris Harvey College.

Survivors include the widow, Goldie E. Glass; a daughter, Mrs. Joseph E. Ballengee of Columbus, Ohio; a son, Dr. Henry R., Jr., of Charleston; a sister, Mrs. Frances Shreve of Fairmont; and two brothers, Dr. W. J., Sr., of Sissonville and George, of Charleston.

MEDICAL CENTER NEWS—(Continued)

The University of Chicago Hospitals and Clinics—Lawrence A. Krames, Greensboro, N. C.

Washington (Pa.) Hospital—Robert G. Lesnock, Washington, Pennsylvania.

U. S. Naval Hospital, Bethesda, Md.—Clayton E. Linkous, Jr., Holden.

Monmouth Medical Center, Long Branch, N. J.—Robert L. Lorenzo, West Long Branch, New Jersey.

St. Francis General Hospital, Pittsburgh—John McSorley III, Pittsburgh; and Robert N. Slotkin, Lancaster, Pennsylvania.

Milwaukee (Wisc.) County General Hospital—William A. Neal, Huntington.

U. S. Naval Hospital, Philadelphia—Phillip M. Park, Petersburg.

Lankenau Hospital, Philadelphia—Ferrel J. Pauletto, Beckley.

Mercy Hospital, Pittsburgh—Joseph J. Schwerha, Venetia, Pennsylvania.

Highland Hospital of Rochester (N. Y.)—Barry Selmanowitz, New York City.

Good Samaritan Hospital, Phoenix, Ariz.—Frederic N. Stimmell, Fairmont; and Arthur A. Trowbridge, Jr., Morgantown.

University Hospitals, Madison, Wisc.—Samuel A. Strickland, Summersville.

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Richard D. Gill, M. D.

Neurological Surgery:
James S. Rogers, M. D.
Frank M. Hudson, M. D.

Internal Medicine
Charles H. Hiles, M. D.
Albert M. Valentine, M. D.
James A. Jacob, Jr., M. D.

Psychiatry and Neurology:
Albert L. Wanner, M. D.
Stephen D. Ward, M. D.
David H. Smith, M. D.

Roentgenology:
William K. Kalbfleisch, M. D.

Clinical Laboratories:
Donna Bryan, M. T.

Technologists:
Electrocardiography:
Patricia Pastor, R. N.
Electroencephalography:
Joann Green, R. N.
June Althar, R. N.
Roentgenology:
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County Societies

B-R-T

Dr. B. B. Richmond, Medical Director of the Health Insurance Benefits Unit of the State Health Department, was guest speaker at a meeting of the Barbour-Randolph-Tucker Medical Society, which was held at Mellie's Restaurant in Philippi on April 12.

Doctor Richmond described the work of his unit and said it behooves all physicians to try to make the Medicare program work satisfactorily so that local control may be maintained.

Twenty-one members and guests attended the meeting.—A Kyle Bush, M. D., Secretary.

* * * *

CABELL

The Cabell County Medical Society met jointly with the Cabell County Bar Association at the Hotel Frederick in Huntington on April 14.

The principal speaker was Mr. Moe Levine of New York City, an authority on law and its relation to medicine. The subject of his talk was "Reciprocal Duties and Obligations of the Two Professions."

"While doctors are working for the physical rehabilitation of their clients, we lawyers are fighting for their financial rehabilitation," he said.

He said malpractice suits are showing a steady increase from year to year, and he suggested that every physician protect himself with at least $500,000 worth of malpractice insurance.

More than 100 members and guests attended.—Harold N. Kagan, M. D., Secretary.

* * * *

EASTERN PANHANDLE

The regular monthly meeting of the Eastern Panhandle Medical Society was held at the Shenandoah Hotel in Martinsburg on April 13.

Dr. L. Walter Fix reported that Newton D. Baker Hospital has received approval to start a Medical Technicians School. The Society decided to underwrite the tuition of one or more students on a loan basis.

* * * *

FAYETTE

Dr. B. B. Richmond, Medical Director of the Health Insurance Benefits Unit of the State Health Department, was guest speaker at the regular monthly meeting of the Fayette County Medical Society, which was held at Laird Hospital in Montgomery on April 6.

Doctor Richmond discussed the Medicare program.

* * * *

HARRISON

Dr. James A. Thompson of Clarksburg was elected President of the Harrison County Medical Society at the organization's annual business meeting at the Stonewall Jackson Hotel in Clarksburg on May 5.

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TRADE MARK

He succeeds Dr. Richard K. Hanifan. Other new officers include: Dr. Paul E. Gordon, President Elect; Dr. E. Leon Linger, Secretary; and Dr. J. D. H. Wilson, Treasurer.

Committee chairmen presented their annual reports.—Paul E. Gordon, M. D., Secretary.

* * * *

McDOWELL

Drs. Herbert H. Butler and L. D. Mullins were guest speakers at the regular monthly meeting of the McDowell County Medical Society, which was held at Stevens Clinic Hospital in Welch on April 13.

They presented a clinical pathological conference on a case of unilateral neck mass in a 12-year-old boy who had received radiation to the thymus gland in infancy.

Dr. John S. Cook, Secretary of the Society, was directed to send a telegram to the Chairman of the Senate Commerce Committee supporting Senate Bill 3138 (Mondale) without amendments.

Dr. Stephen Mamick, President of the Society, presided at the meeting, which was attended by 12 members and three guests.—John S. Cook, M. D., Secretary.

* * * *

MERCER

Dr. Carl C. Barger of Bluefield was principal speaker at the regular monthly meeting of the Mercer County Medical Society, which was held at the West Virginian Hotel in Bluefield on April 18.

Doctor Barger gave an interesting talk on bacterial meningitis. He presented a series of eight cases seen at Bluefield Sanitarium and said that with the advent of antibiotics the mortality rate has dropped from 50 per cent to 10 per cent.

Dr. Jorge Piedra was unanimously elected to membership as a transfer from the Wyoming County Medical Society.

The Society authorized a donation of $70 to Camp Kno-Koma.—John J. Mahood, M. D., Secretary.

* * * *

MONONGALIA

Dr. B. B. Richmond, Medical Director of the Health Insurance Benefits Unit of the State Health Department, was guest speaker at the regular monthly meeting of the Monongalia County Medical Society which was held in Morgantown on April 5.

Doctor Richmond's subject was "The Medicare Program." A discussion period followed the talk.

The Society voted to donate $70.00 to send a diabetic child to Camp Kno-Kama.—Robert Greco, M. D., Secretary.

* * * *

PARKERSBURG ACADEMY

Members of the Parkersburg Academy of Medicine and their wives were guests of the Washington County (Ohio) Medical Society at a recent dinner in Marietta, Ohio.

Dr. Jack E. Tetirick of Columbus, Ohio, was guest speaker. He discussed his experiences aboard the medical ship "Hope."

More than 35 physicians and their wives attended the meeting.

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CABELL

Mrs. Arthur C. Chandler of Charleston was guest speaker at a luncheon meeting of the Woman's Auxiliary to the Cabell County Medical Society which was held at the Hotel Frederick in Huntington on April 12.

Mrs. Chandler told of her and Doctor Chandler's experience aboard the hospital ship S. S. Hope. She worked as a statistician aboard ship.

Mrs. C. Stafford Clay was chairman for the luncheon.

★ ★ ★ ★

MARION

The Woman's Auxiliary to the Marion County Medical Society held its annual installation tea at the home of Dr. and Mrs. Robert G. Janes in Fairmont on May 10.

Mrs. Wilson P. Smith of Huntington, President of the Woman's Auxiliary to the West Virginia State Medical Association, installed the following officers of the local Auxiliary:

Mrs. James E. Wotring, President; Mrs. Robert J. Sidow, President Elect; Mrs. Harry C. Fleming, Vice President; Mrs. Frederick G. Shaffer, Secretary; and Mrs. John J. Coogle, Treasurer.

Mrs. Sidow succeeded Mrs. Janes.

★ ★ ★ ★

MONONGALIA

The Woman's Auxiliary to the Monongalia County Medical Society held a dinner meeting at Lakeview Country Club in Morgantown on April 7.

Special guests were members of Caduceanns, wives of West Virginia University School of Medicine students.

A highlight of the program was a showing of the latest in children's fashions.—Mrs. Dean Goplerud, Corresponding Secretary.

★ ★ ★ ★

OHIO

The Woman's Auxiliary to the Ohio County Medical Society sponsored a semi-formal benefit dance at Oglebay Park in Wheeling on May 14.

Proceeds went to a Medical Career Loan Fund.

Mesdames W. E. Ackermann and W. Carroll Boggs were co-chairmen of arrangements.

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Book Reviews

FUNDAMENTALS OF CLINICAL HEMATOLOGY.—By Byrd S. Leavell, M. D., Professor of Internal Medicine, School of Medicine, University of Virginia; Oscar A. Thomp, Jr., M. D., Associate Professor of Internal Medicine, School of Medicine, University of Virginia. W. B. Saunders Company, Philadelphia, London. 1966 Pp. 597. Illustrated. Price: $12.50.

This book, as stated in the original preface, "comprehensive but not encyclopedic, that could serve for a review and reorientation in the field," is now in its second edition. The goals of this edition are similar, but the expanding field has necessitated addition of nearly 100 pages to achieve even limited scope.

The general approach to the subject is orderly and well conceived with morphology presented first. Then follows consideration of red cell metabolism and abnormalities, hemostasis, white cell metabolism and abnormalities, lymphomas, dysproteinemias, and their treatment.

Many chapters have been revised, particularly those dealing with hemorrhagic and protein disorders. Others have been expanded with no change in the original format. The section on anemias has been consolidated from 18 chapters on clinical syndromes to five large subdivisions based on Etiology; Vitamin B^{12} and Folic Acid, Iron Metabolism, Bone Marrow Failure, Hemolytic Anemias and Anemia Resulting from Other Disorders.

Actual case histories are presented to illustrate appropriate points. Direct references are frequently cited from an extensive bibliography. A final chapter outlines clinical and laboratory procedures in hematology.

The authors express appreciation to several members of the Faculty of Medicine at the University of Virginia. The first two names, Dr. Daniel N. Mohler, Department of Hematology, and Dr. O. B. Bobbitt, Department of Pathology, may strike a familiar note as both are Charleston natives.

The book is recommended to students, pediatricians and generalists—it admirably fulfills the aims of the authors.—John M. Hartman, M. D.

* * * *

GASTROENTEROLOGY.—By Henry L. Bockus, M. D., Emeritus Professor of Medicine, University of Pennsylvania Graduate School of Medicine; and present and former colleagues at the University of Pennsylvania Graduate School of Medicine and School of Medicine. Pp. 1352, with numerous illustrations. Philadelphia and London: W. B. Saunders Company. 1965. Second Edition. Volume III. Price $30.

The third Volume of Bockus Gastroenterology is the first revision since the original edition was published in 1947. It is larger by 300 pages and includes all that has weathered 20 years of medical scrutiny, plus detailed presentation of all new developments in this vast field of medicine.

This volume has reference to diseases of the liver, biliary tract, pancreas and secondary gastrointestinal

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BOOK REVIEWS—(Continued)

diseases. It is prepared by 40 contributors, all of whom have esteem in their particular field.

The preface states there is an intimate correlation of basic material with clinical data; both diagnostic and therapeutic, medical and surgical. Although written by various authors, the subject matter has been melded so that there is continuity of thought and substance.

The section devoted to diagnostic tests and procedures in liver disease almost doubles the coverage of the initial edition and will be a guide to internists in their struggle through this maze of medicine. Radioisotope visualization of the liver by scanning techniques is a new chapter and its indications and limitations are precisely stated. The case for viral hepatitis is defined as lucidly as this problem permits. Like all chapters, this one contains numerous references for readers who find insufficient material in the text.

New chapters on angiography in diagnosis, and abdominal vascular disease, bring these recent concepts in diagnosis and abdominal symptomatology to the interested physician in readable form.

The two column format is a distinct improvement. The index, amount and quality of reference material are adequate for any student. This volume is not to be shoved aside as a reference volume; it has application to everyday medicine.

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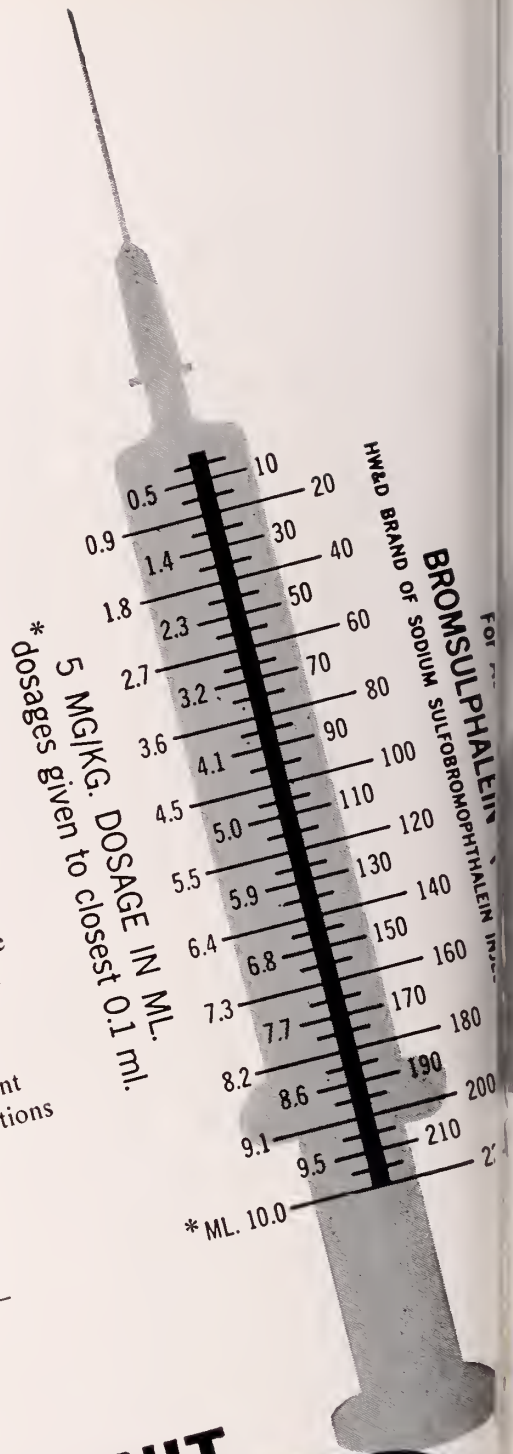

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Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

Supplied: 'Miltown' (meprobamate) is available in two strengths: 400 mg. scored tablets and 200 mg. coated tablets. 'Meprotabs' (meprobamate) is available as 400 mg. white, coated, unmarked tablets. *Before prescribing, consult package circular.*

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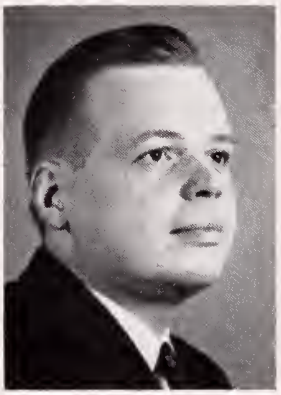
WVU Medical Center
—News—

Dr. William W. Fleming, a member of the faculty of the WVU School of Medicine since 1960, has been appointed Chairman of the Department of Pharmacology, effective July 1. Doctor Fleming succeeds Dr. Daniel T. Watts, who moved to the Medical College of Virginia as Dean of Graduate Studies.



William W. Fleming, Ph. D.

A native of Washington, D.C., Doctor Fleming received an A.B. degree in 1954 at Harvard University and a Ph.D. degree in 1957 at Princeton University. For the next three years he studied as a Postdoctoral Fellow in Pharmacology at Harvard Medical School.

He joined the Department of Pharmacology as Assistant Professor and was promoted to Associate Professor in 1964. He is a member of the Medical School Committee on Admissions and Promotions.

Two years ago, Doctor Fleming received the MacLachlan Memorial Award, which is presented annually to "the basic science teacher who, in the opinion of the second year class, demonstrated unusual teaching ability and a sincere interest in the progress of the entire class."

His research centers on autonomic and cardiovascular pharmacology, and he has published 47 articles in scientific journals.

Doctor Fleming will work under Dr. Clark K. Sleeth, Dean of the School of Medicine, who commented: "Doctor Fleming's broad knowledge of the total educational program in medicine, his enthusiasm as a teacher and his distinguished career as an investigator made him eminently qualified to head one of the most progressive departments of pharmacology in the country."

Chair of Pulmonary Diseases

The West Virginia Tuberculosis and Health Association has extended its support of the Chair of Pulmonary Diseases at the School of Medicine for another three years.

The School will receive $10,000 a year for three years for research in pulmonary diseases. The chair has been occupied since its inception in 1960 by Dr Charles E. Andrews, Professor of Medicine.

• **Compiled from materiol furnished by Arthur V. Ciervo, Director, Medical Center News ond Informotion Services, Morgontown, West Virginio.**

Honor Society Installs Members

Dr. Byron M. Bloor, Chairman of the Division of Neurosurgery of the School of Medicine, and nine medical students were installed recently as members of Alpha Omega Alpha, honor medical society.

The students are: Paul Malone, Grafton; David Santrock, Dunbar; Clayton Linkous, Jr., Holden; Arthur Trowbridge, Jr., Morgantown; Joseph Metz, Erie, Pennsylvania; Thomas Amend, Morgantown; Lawrence Krames, Newburgh, New York; James Brantly, St. Albans; and Patsy Cipolloni, Jr., Masontown.

Anesthesiology Demonstration

Dr. George J. Thomas of Pittsburgh will demonstrate safeguards against explosions of anesthetic agents in operating and delivery rooms at the Medical Center on Friday, July 29. The demonstration will begin at 4 P. M. in the Main Auditorium.

Doctor Thomas is Emeritus Professor and Past Chairman of the Section on Anesthesiology at the University of Pittsburgh School of Medicine.

Pre-Commencement Program

Dr. Victor A. McKusick was principal speaker at the pre-commencement ceremony at the School of Medicine on May 28. He presented a paper on "Genetic Studies of the Amish."

Doctor McKusick is Chief of the Division of Medical Genetics at Johns Hopkins University.

Awards

The Edward J. Van Liere Award was presented on May 28 to Jeffery S. Shultz of Shepherdstown. The award, consisting of a medal and $100 in cash, is presented annually to the medical student who presents the best paper on original research at the annual student research convocation.

Dr. John M. Slack, Chairman of the Department of Microbiology in the School of Medicine, received the MacLachlan Memorial Award. The award is presented each year to a basic science teacher, who, in the opinion of the second-year class, demonstrates unusual teaching ability and a sincere interest in the progress of the entire class.

(Continued on Page xxxvii)

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Precautions: The dosage of ganglionic blocking agents, veratrum, or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Electrolyte disturbances are possible in cirrhotic or digitalized patients.

Side Effects: Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, and rashes may occur.

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References: 1. Telfeyan, S. A.: Clin. Med. *70*:1668, 1963. 2. Shepard, H. L.: J. Am. Geriatrics Soc. *11*:363, 1963. 3. Cummings, D. E.; Goodman, R. M., and Steigmann, F.: J. Am. Geriatrics Soc. *12*:161, 1964. 4. Castleman, B., ed.: New England J. Med. *268*:1462, 1963.

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The Month in Washington

• From the Washington Office of the American Medical Association.

ADMINISTRATION officials say that the doctor-patient relationship should not be impaired under Medicare. Dr. Philip R. Lee, Assistant Secretary of Health, Education and Welfare for health and scientific affairs, said in an interview that federal officials, in drafting Medicare regulations, had been doing their utmost to insure that the traditional doctor-patient relationship is preserved.

"The guidelines for the Medicare Program were developed with the close cooperation of so many physicians and other people in the health care field that this will provide the best assurance for the physicians, for the government, for Congress and for the public that the implementation of Medicare will not alter the fundamental and vital personal relationship between the doctor and the patient," Doctor Lee said. "This was clearly the intent of Congress."

Doctor Lee termed the cooperation of physicians and hospital officials in developing Medicare guidelines as "extraordinary." He said he personally expects the doctor-patient relationship to improve under Medicare because removal to a large extent of the financing problem will give a physician more leeway in ordering laboratory tests and sending a patient to a hospital.

"Our most important concern in implementing the Medicare Program is education," Doctor Lee said. "The education extends to the doctor, the patient and administrators of the program."

Doctor Lee's office published a brochure for patients and another for doctors explaining what the medical insurance program does and doesn't do.

The Social Security Administration said that nine out of 10 of those 65 and over had enrolled in Plan B of Medicare by the second signup deadline of midnight, May 31. The original deadline was extended for two months in an effort to get a reply from as many as possible of the 19.1 million aged persons eligible. More than 400,000 signed up during the two months, bringing the total to about 17.2 million. About one million said they didn't want Plan B coverage. Those who did not sign up this time will not have another opportunity until October 1, 1967, and they then will have to pay at least 10 per cent higher premiums.

Meeting at White House

President Johnson invited about 200 physicians and hospital administrators to a White House meeting on June 15 "to examine problems that may arise and to discuss cooperative arrangements so that the (Medicare) program will get off to a good sart."

In addition to President Johnston, speakers at the meeting included HEW Secretary John W. Gardner; HEW Undersecretary Wilbur J. Cohen; Doctor Lee; Surgeon General William H. Stewart; Social Security Commissioner Robert M. Ball, and Arthur E. Hess, Director of Medicare.

Draft Call for Physicians Reduced

The Defense Department has slashed by almost one-third—from 2,496 to 1,713—its special draft call for physicians to be delivered to the armed forces this summer. Under the revised doctor draft call, the Army will take 958, the Navy 405 and the Air Force 350.

The Pentagon said casualties in Southeast Asia had been fewer than expected and the number of volunteer physicians had exceeded estimates. In reducing the call by 783, the Defense Department pointed out it had originally issued its request to Selective Service last February. At that time it used best estimates available on the number of additional physicians who would be needed for the buildup of the armed forces in connection with the Viet Nam war.

Medical Quackery

The federal government will conduct a nationwide survey to determine factors that lead people, particularly older persons, to fall for fakes and swindles in the health field.

Seven agencies of the government are joining in the study which was recommended by the Senate Special Committee on Aging Subcommittee on Frauds and Misrepresentations Affecting the Elderly. The study will include various age groups beginning with teenagers, but it will focus on the elderly.

At hearings of the subcommittee, it was estimated that one billion dollars is wasted each year on misrepresented, unnecessary or worthless health products and services with a large share of such spending by older persons, especially those suffering from chronic and incurable diseases.

There is general agreement among the government agencies involved that this waste of money may be greatly reduced if more knowledge is available about why people become victims of medical quackery.

The Food and Drug Administration is coordinating the study and the American Medical Association is among several groups that helped in the planning.

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Pierce D. Nelson, M. D.
Phone: 328-2211

Obituaries

RAYMOND HANGER DUNN, M. D.

Dr. Raymond H. Dunn, 79, died in a hospital in Ronceverte on June 2.

A native of Staunton, Virginia, Doctor Dunn received his M. D. degree in 1910 from the Medical College of Virginia. He began practice in Charleston in 1915 but moved to Lewisburg a few years ago.

He was an honorary member of the Kanawha Medical Society, of which he was a former Secretary, Vice President and President; the West Virginia State Medical Association and the American Medical Association. He once served as Vice President of the State Medical Association.

His other memberships included the West Virginia Hospital Association, the West Virginia Industrial Surgeons and the American College of Surgeons.

Doctor Dunn was the founder of Dunn Hospital in South Charleston. The name of that institution has since been changed to Southern Hills Hospital.

Doctor Dunn was former president of the Kanawha County Court and once headed the old Louden District Board of Education in Kanawha County. He also served on the Kanawha County Selective Service Board.

Survivors include the widow, Mrs. Janet Alexander Dunn; daughters, Mrs. Douglas Staples, Mrs. K. A. Dunlap and Mrs. Janet Holden of Lewisburg, Mrs. George Reeves of Charleston, Mrs. Nancy Von Blond of Sacramento, California; sisters, Mrs. Katherine Butler of Clifton Forge, Virginia, and Mrs. Robert Murray of Atlanta, Georgia; and 12 grandchildren and seven great grandchildren.

* * * *

RAY KESSEL, M. D.

Dr. Ray Kessel of Ripley, a retired physician and surgeon, died in a Clarksburg Hospital on May 31 after a long illness.

Doctor Kessel, 76, was born in Ripley and received his M. D. degree in 1915 from the Chicago College of Medicine and Surgery, now Loyola University. He was Valedictorian of his class.

He served overseas with the Medical Corps of the United States Army during World War I, and served as a Major in the Medical Corps during World War II.

He was an honorary member of the Kanawha Medical Society, of which he was a former President; the West Virginia State Medical Association and the American Medical Association. He also held membership in the Military Surgeons' Association.

Doctor Kessel practiced medicine in Jackson and Kanawha counties for 45 years.

The eldest of three physician brothers, he was preceded in death last September by one brother, Dr. C. R. Kessel, also of Ripley.

Survivors include the widow, Mrs. Kate Miller Kessel; the mother, Mrs. Louisa Kessel; two daughters, Mrs. Katherine Burdette of Logan and Miss Jerry

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Stephen D. Ward, M. D.
David H. Smith, M. D.

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Donna Bryan, M. T.

Technologists:
Electrocardiography:
Betty Bartsch, R. N.
Electroencephalography:
Joann Green, R. N.
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Kessel of Charleston; one son, Dr. Ray M. Kessel of Logan; one brother, Dr. Russel Kessel of Charleston; and eight grandchildren.

* * * *

ARLEY VON McCOY, M. D.

Dr. Arley V. McCoy, 73, of Wheeling, died in a hospital in that city on May 4.

Doctor McCoy was born in Mannington and had practiced medicine for 43 years. He was an honorary member of the Ohio County Medical Society, the West Virginia State Medical Association and the American Medical Association.

He held an A. B. degree from Allegheny College and received his M. D. degree in 1921 from the University of Maryland. He served his internship at University Hospital in Baltimore.

* * * *

HERBERT N. SHANES, M. D.

Dr. Herbert N. Shanes of Grafton was killed in an automobile accident near Pittsburgh on May 22. His wife, Catherine Margaret Shanes, died five days later in a Pittsburgh hospital as a result of injuries received in the accident.

Doctor Shanes, 51, was born in New York City and received a B.S. degree from the College of the City of New York in 1934. He received his M. D. degree in 1938 from the University of Cincinnati School of Medicine.

He had practiced in Cincinnati and Coalwood before moving to Grafton in the 1940s. He was a member of the Taylor County Medical Society, the West Virginia State Medical Association and the American Medical Association. During World War II, he served as a Major in the Medical Corps of the United States Army.

Survivors include the parents, Mr. and Mrs. Ruben Shanes of Grafton; a brother, Louis, of New York; and four children, Mrs. Patricia Walls, Richard Shanes, a student at Greenbrier Military Academy; Diane Shanes, a student at Potomac State College; and Robert Shanes, a junior high school student.

* * * *

HAROLD W. ULCH, M. D.

Dr. Harold W. Ulch of Parkersburg died in Bridgeport on May 28. He had traveled to Bridgeport to attend the wedding of his son that same day. He was 60.

Doctor Ulch, a native of Fremont, Ohio, was graduated from Wayne University and received his M. D. degree in 1935 from the Wayne University School of Medicine. He interned and served a residency at Harper Hospital in Detroit, 1935-40. Following his training, he practiced in Detroit for six years before moving to Parkersburg where he practiced his specialty of surgery since 1946.

A past president of the Parkersburg Academy of Medicine, Doctor Ulch also was a member of the West Virginia State Medical Association and the American Medical Association. He served as Chairman of the City Planning Commission in Parkersburg.

Survivors include the widow, Elizabeth Ulch; a son, George, a student at West Virginia University; two daughters, Virginia, also a student at WVU, and Mary Alice Thompson of Morgantown.

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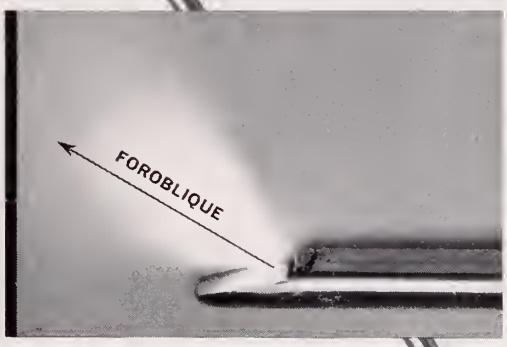

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County Societies

CABELL

Mr. William Frazier, Huntington attorney, was guest speaker at the regular monthly meeting of the Cabell County Medical Society, which was held at the Hotel Frederick in Huntington on May 12.

Mr. Frazier gave an interesting talk on "Wills and Estates," and there was an active discussion period.

The Society unanimously approved applications for membership from Drs. Larry B. Craycraft and Dorval H. Donahoe.

Drs. Joseph E. Ricketts, Roy A. Edwards, Jr., Joseph M. Farrell and David A. Haught were elected delegates to the Annual Meeting of the West Virginia State Medical Association in August. Holdover delegates are Drs. John F. Otto, Jr., Walter R. Wilkinson, Thomas J. Holbrook and Thomas F. Scott.

Thirty-six members and guests were present.—Harold N. Kagan, M. D., Secretary.

* * * *

CENTRAL WEST VIRGINIA

Drs. B. B. Richmond of Charleston and Roland E. Schmidt of Morgantown were guest speakers at the Spring meeting of the Central West Virginia Medical Society which was held in Gassaway on May 12.

Doctor Richmond, Medical Director of the Health Insurance Benefits Unit of the State Health Department, spoke on "The Medicare Program." Doctor Schmidt, Assistant Professor of Pediatrics at the WVU School of Medicine, presented a paper entitled "Cardiac Problems of the Newborn."

Dr. George T. Hoylman of Gassaway was Chairman of Arrangements for the gathering, which included golf, a tour of the Sutton Dam and a dinner meeting.

Dr. Charles T. Lively of Weston, President of the Society, presided at the business session. Delegates to the Annual Meeting of the West Virginia State Medical Association in August will include Doctors Lively, Robert L. Chamberlain of Buckhannon, C. R. Davisson of Weston and John E. Echols of Richwood.

* * * *

MERCER

Judge Howard Jarrett of Mercer County Intermediate Court was guest speaker at the regular monthly meeting of the Mercer County Medical So-

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Meprobamate: Careful supervision of dose and amounts prescribed is advised; especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of pre-existing symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dose—operation of motor vehicles, machinery or other activity requiring alertness should be avoided. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia, the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor, and respiratory collapse.

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ciety which was held at the West Virginian Hotel in Bluefield on May 16.

Judge Jarrett discussed juvenile delinquency and said 80 per cent of the cases involved male offenders.

The Society voted to contribute $100 to the Mercer County Workshop.—John J. Mahood, M. D., Secretary.

* * * *

MONONGALIA

Dr. Edward G. Stuart, Vice President of the West Virginia University Medical Center, was guest speaker at the regular monthly meeting of the Monongalia County Medical Society which was held in Morgantown on May 3.

The Society elected Dr. Stancil E. D. Johnson to membership.

Forty-five members and three guests attended the meeting.—Robert Greco, M. D., Secretary.

* * * *

McDOWELL

Dr. David M. Wayne, psychiatrist in charge of the Bluefield Mental Health Clinic, was guest speaker at the regular monthly meeting of the McDowell County Medical Society which was held at Grace Hospital in Welch on May 11.

Doctor Wayne gave an interesting talk on depression and showed a movie, "The Faces of Depression."

The Society voted to sponsor one campership to Camp Kno Koma.

Ten members and three guests attended the meeting.—John S. Cook, M. D., Secretary.

Woman's Auxiliary

to the

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Corresponding Secretary: Mrs. M. L. White, Jr., Huntington
Parliamentarian: Mrs. D. E. Greeneltch, Wheeling

CENTRAL WEST VIRGINIA

Mrs. Charles T. Lively of Weston was installed as President of the Woman's Auxiliary to the Central West Virginia Medical Society during a meeting in Gassaway on May 12.

Mrs. Lively succeeds Mrs. Edward H. Hunter of Richwood. Mrs. C. R. Davisson of Weston, Second Vice President of the Woman's Auxiliary to the West Virginia State Medical Association, officiated at the installation of officers.

Other new officers are: Mrs. W. W. Huffman of Gassaway, First Vice President; Mrs. Hunter, Second Vice President; Mrs. Earl L. Fisher of Gassaway,

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Secretary; and Mrs. Rigoberto Ramirez of Buckhannon, Treasurer.

Reports were made on the Auxiliary's recent activities. Members served 685 community service hours, observed Doctors' Day and had all members contributing to AMA-ERF for the benefit of the West Virginia University School of Medicine.—Mrs. John E. Echols, Publicity Chairman.

* * * *

EASTERN PANHANDLE

Mrs. Daniel E. Hendricks of Martinsburg was installed as President of the Woman's Auxiliary to the Eastern Panhandle Medical Society at a coffee which was held on May 25 at the home of Mrs. V. L. Glover.

She succeeds Mrs. L. Walter Fix. Other new officers are Mrs. E. Walter Rice, President Elect; Mrs. W. R. McCune, Vice President; Mrs. William L. Rodgers, Secretary; and Mrs. V. L. Glover, Treasurer.

* * * *

GREENBRIER VALLEY

Mrs. Wilson P. Smith of Huntington, President of the Woman's Auxiliary to the West Virginia State Medical Association, was guest speaker at a meeting of the Woman's Auxiliary to the Greenbrier Valley Medical Society. The meeting was held on May 17 at the home of Mrs. James P. Baker in White Sulphur Springs.

Twelve members attended the meeting.

* * * *

KANAWHA

Mrs. A. A. Abplanalp of Charleston was installed as President of the Woman's Auxiliary to the Kanawha Medical Society during a meeting of the Auxiliary at the home of Dr. and Mrs. R. R. Summers in Charleston.

She succeeds Mrs. James H. Walker.

Other new officers are: Mesdames J. L. Mangus, President Elect; Willis D. Garrard, First Vice President; George V. Hamrick, Second Vice President; James T. Spencer, Third Vice President; Grover B. Swoyer, Fourth Vice President; W. Alva Deardorff, Treasurer; Ralph J. Holloway, Corresponding Secretary; David Bachwitt, Recording Secretary; J. Dennis Kugel, Financial Secretary; Thomas G. Potterfield, Historian; and Marion F. Jarrett, Parliamentarian.

Auxiliary members held a picnic in conjunction with the meeting.

* * * *

MARION

Mrs. James E. Wotring was installed as President of the Woman's Auxiliary to the Marion County Medical Society at a tea held at the home of Dr. and Mrs. Robert G. Janes in Fairmont on May 10.

Mrs. Wotring was installed by Mrs. Wilson P. Smith of Huntington, President of the Woman's Auxiliary to the West Virginia State Medical Association.

Other new officers are: Mrs. Robert J. Sidow, President Elect; Mrs. Harry C. Fleming, Vice President;

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WOMAN'S AUXILIARY—(Continued)

Mrs. Frederick G. Shaffer, Secretary and Mrs. John J. Coogle, Treasurer.

* * * *

MERCER

Mrs. John J. Mahood of Bluefield was installed as President of the Woman's Auxiliary to the Mercer County Medical Society at a tea held in Bluefield in May.

She succeeds Mrs. C. D. Pruett.

Other new officers are: Mrs. John J. Bryan, President Elect; Mrs. J. Elliott Blaydes, Jr., Vice President; Mrs. James E. McGee, Jr., Secretary; and Mrs. Frank J. Holroyd, Treasurer.

About 25 members of the Auxiliary attended the tea, which also honored members of the Health Careers Girls Club at Beaver High School.

* * * *

MONONGALIA

Mrs. Robert Greco took office as President of the Woman's Auxiliary to the Monongalia County Medical Society at a luncheon meeting which was held at Lakeview Country Club in May.

Mrs. Greco and other officers were installed by Mrs. Rupert W. Powell of Fairmont, Fourth Vice President of the Woman's Auxiliary to the West Virginia State Medical Association.

Other new county auxiliary officers are: Mrs. Bernard Zimmermann, Vice President; Mrs. Walter H.

Radiology:
KARL J. MYERS, M. D.

Pathology:
S. D. WU, M. D.

Surgery:
HU C. MYERS, M. D.
A. KYLE BUSH, M. D.

Gynecology and Obstetrics:
RAYMOND W. CRONLUND, M. D.

Internal Medicine:
JOHN E. LENOX, M. D.
ERNEST G. GUY, M. D.

Anesthesiology:
G. E. HARTLE, M. D.

Dentistry:
GLENN B. POLING, D. D. S.

Broaddus Hospital Resident Staff:
LUIS GUTIERREZ, M. D.
JOSIAH THOMPSON, M. D.
HONORATO P. OLAY, M. D.
AMADO G. CHANCO, M. D.

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Moran, Jr., President Elect; Mrs. Thomas M. Howes, Treasurer; and Mrs. J. J. Lawless, Recording Secretary.

More than 25 members attended the installation.

* * * *

PARKERSBURG ACADEMY

Mrs. Ray Kessel of Logan, Third Vice President of the Woman's Auxiliary to the West Virginia State Medical Association, installed officers of the Woman's Auxiliary to the Parkersburg Academy of Medicine at a meeting in Parkersburg in May.

Mrs. Donald R. Lantz of Parkersburg assumed the presidency. Other new officers are: Mrs. Robert W. Howes, Jr., President Elect; Mrs. Watson F. Rogers, First Vice President; Mrs. Robert D. Crooks, Second Vice President; Mrs. Alfonso Morales, Recording Secretary; Mrs. Robert C. Cowan, Jr., Corresponding Secretary; and Mrs. Rex Dauphin, Treasurer.

A gift of appreciation was presented to the retiring President, Mrs. George McCarty.

* * * *

RALEIGH

Mrs. Everett B. Wray was installed as President of the Woman's Auxiliary to the Raleigh County Medical Society at the May luncheon meeting, which was held at the Black Knight Country Club. She succeeds Mrs. Warren D. Elliott.

Other new officers are: Mrs. George A. Miller, President Elect; Mrs. John W. Whitlock, Vice President; Mrs. C. A. Stevenson, Recording Secretary; Mrs. Charles W. Nelson, Jr., Corresponding Secretary; and Mrs. A. G. Bowles, Treasurer.

Mrs. Wilson P. Smith of Huntington, President of the Woman's Auxiliary to the West Virginia State Medical Association, reported on plans for the Auxiliary's Annual Meeting at The Greenbrier in August.

MEDICAL CENTER NEWS—(Continued)

The student body dedicated its 1966 yearbook to Dr. Nicholas W. Fugo, Chairman of the Department of Obstetrics and Gynecology.

The Merck Manual and Roche awards and Lange and Mosby book awards were presented to 17 medical students of all four classes.

PG Course in Anesthesiology

More than 50 physicians from throughout West Virginia attended a postgraduate course in anesthesiology at the Medical Center, May 14-15.

Visiting lecturers were Drs. Louis Baker of the University of Maryland, Douglas Eastwood of the University of Virginia, Martin Helrich of Maryland and John Steinhaus of Emory University. Several members of the faculty of the WVU School of Medicine also presented papers.

The course was sponsored by the WVU Division of Anesthesiology and the West Virginia Society of Anesthesiologists.

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ANESTHESIOLOGY
DAVID H. GATHERUM, M. D.

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Book Reviews

CARING FOR THE AGED—By Bertram B. Moss, M. D. Doubleday & Company, Inc., New York. 1966. Pp. 372. Price: $4.95.

This book was written by a general practitioner who is medical director of a suburban nursing home. It is designed to answer the questions of patient and family concerning aging and the care of the aged. We have decreed 65 years as the cut off age between middle life and old age but the life of the aged varies from robust health and full occupation to the "vegetable" with gastric and bladder intubation.

In any consideration of this group of people, we must remember that their situation has changed tremendously in one generation. Thirty years ago the transition from the 60-hour week of hard labor to retirement was devastating but in 1966 the change from the 35 hours, which are full of coffee breaks, to the golden age of senior citizen is not difficult.

The author points out that with the development of new skills and automation, the labor force will diminish numerically and experience will be synonymous with obselescence and the labor life of an individual will shrink. Retirement life will increase until it equals the years of labor life.

The book has excellent chapters on retirement, unemployment and money matters. It provides basic information and the intelligent approach to Medicare. The chapter on nursing home and medical care is most helpful to patients and to their attending physician. A large section of the book gives specific advice concerning definite types of illness, including emotional sickness.

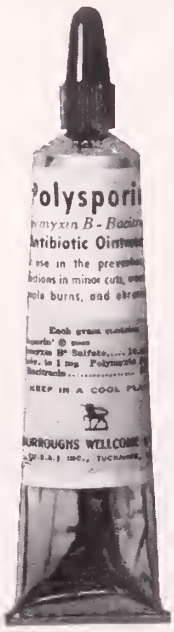
Along with the split level ranchhouse and the two-car garage, America now has produced the five-generation family. A conservative estimate indicates there are now 300,000 such families. The two top generations come under the category of aged. We now have more than 3,000,000 people over 85 years. These people and their physicians will be benefited by referral to this small but enyclopedic reference to the care of the aged.

NEW DRUGS: 1966 Edition Evaluated by AMA Council on Drugs, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610, 1966. Price: $4.

The first edition of this book was published in July, 1965. Over 30,000 copies were sold within the first six months and the AMA had to order two extra printings. The second (1966) edition has been enlarged and improved by the addition of five new chapters and 30 new drug monographs. Many of the individual drug evaluations have been revised, as have

(Continued on Page xxxix)

in treating topical infections, no need to sensitize the patient



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Correspondence

Dr. George F. Evans, Editor
The West Virginia Medical Journal
122 South Sixth Street
Clarksburg, West Virginia

Dear Sir:

As a member of the Insect Allergy Committee, American Academy of Allergy, I wish to comment on the article, "Oral Dexamethasone in Insect Bites," by Abraham Tow, M. D., which appeared in the June, 1966, issue of *The Journal.*

According to the report, Insect Sting Allergy (JAMA: Vol 193, Pp. 109-114, July 12, 1965), prepared by the Insect Allergy Committee of the American Academy of Allergy, the following statement concerning treatment is made as a result of a study of 2,606 insect sting reactions:

> "In the treatment of the acute, immediate insect-sting reaction the primary drug of choice is epinephrine. *Antihistamines and steroids are suggested only as supplemental medication* or for treatment of mild or delayed-type reactions. Isoproterenol acts rapidly, but is not a vasoconstrictor and does not counteract shock symptoms. Standard supportive measures for treatment of shock or anoxia may be indicated; tracheotomy may be required for angioedema of the larynx or for a severe asthmatic type of reaction."

This quotation should be brought to the attention of the readers of *The West Virginia Medical Journal* in order that no confusion be encountered in the management of insect sting reactions. Whereas Doctor Tow's article is interesting, it nevertheless may leave the physician with the impression that the treatment of choice in insect sting allergy is Dexamethasone or a similar corticosteriod and not Epinephrine which has been recommended in the JAMA report.

Merle S. Scherr, M. D.
805 Atlas Building
Charleston, West Virginia

The letter from Doctor Scherr was referred to Doctor Tow who submits the following reply:

The West Virginia Medical Journal
Atlas Building
Box 1031
Charleston, West Virginia
Attention: William H. Lively,
Managing Editor

Dear Sir:

I welcome Dr. Scherr's comments on my paper. They are definitely in order.

Epinephrine has been the drug of choice in treating this condition since time immemorial. But how long does its action persist and is it always effective?

I do not question its immediate use where the cessation of breathing is imminent. In this situation, however, I would recommend that a large dose of a steroid be given at the same time to prolong and potentiate the action of the epinephrine. (Dexamethasone 6 to 8 mgm. I.V. or I.M.)

In our hands Dexamethasone alone has proven an ideal drug. However, it must be given in the large doses recommended.

Abraham Tow, M. D.
Guyan Valley Hospital
Logan, West Virginia

How to Eliminate Confusion

Were each drug prescribed a simple, chemically pure substance, one would not be so concerned. However, even the potency of natural products may vary from batch to batch, particularly in the case of the most active ingredients.

Consider the great variety of preparations of digitalis, strophanthus, belladonna and other similar substances. Consider also the variety of substances derived from the thyroid gland and other glandular products. In such instances, the simple statement of a generic name does not begin to convey to the user or the prescriber a real picture of the quality of the product.

Pharmaceutical manufacturers have offered to the American consumer a variety of preparations from which to choose; the manufacturer, by giving his product a name exclusively his own, identifies that product to the prescriber and the user, and eliminates the possibility of confusion.—Morris Fishbein, M. D., in *Postgraduate Medicine.*

BOOK REVIEWS—(Continued)

some of the general discussions which review the older drugs at the beginning of each chapter.

New Drugs contains individual monographs on 290 single-entity products that have been marketed in the U. S. within the last 10 years. Each monograph gives information on the drug's actions and uses; adverse reactions; contraindications or precautions; dosage and routes of administration; preparations and their available sizes and strengths. These brief and clearly written statements provide the practicing physician with an independent and unbiased assessment of the more recently introduced drugs. The evaluations, which are based on a study of all the laboratory and clinical research data by the AMA's Council on Drugs and its consultants, will be of great assistance to the physician in the day-to-day conduct of his practice. Since a monograph on a drug is included whether or not the Council's opinion is favorable, *New Drugs* is in no sense a list of approved or accepted drugs. Drugs are indexed by their nonproprietary (generic) and trade names; Canadian trade name equivalents are also given.

The simplest way to prevent a cold is to eat plenty of onions and garlic. Not that this has a direct effect on the virus, but it keeps people away, among them those who are infectious.—*The Lancet.*

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AUGUST
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99TH ANNUAL MEETING

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WVU Medical Center
—News—

• **Compiled from material furnished by Arthur V. Ciervo, Director, Medical Center News and Information Services, Morgantown, West Virginia.**

Dr. Paul A. Miller, President of West Virginia University, has announced several appointments to the faculty and staff of the WVU School of Medicine.

Dr. Richard C. Juberg, a native of Bismarck, North Dakota, has been employed as Director of a new clinic in human genetics and as Assistant Professor of Pediatrics.

Doctor Juberg attended Carleton College in Massachusetts and received his M. D. degree in 1956 from the University of Michigan. He received a Ph. D. degree in human genetics this year from the same school.

For the past five years, Doctor Juberg has been instructor in pediatrics and human genetics at Michigan. He previously taught in the Division of Biological Sciences at the University of Chicago.

Dr. Ludwig Gutmann has joined the faculty as Assistant Professor of Neurology. A native of Farmingdale, New Jersey, Doctor Ludwig attended Princeton University and received his M. D. degree in 1959 from Columbia University.

Until recently, Doctor Ludwig was a National Institutes of Health Fellow in Neurophysiology at the Mayo Graduate School of Medicine.

The Department of Obstetrics and Gynecology has added Dr. Bienvenido Benach to its faculty as an Assistant Professor.

Doctor Benach was born in Cuba and received his M. D. degree in 1940 from the University of Havana. For 20 years following his graduation he taught at his alma mater, the National Medical College and the Medical College of Sagua La Grande. Prior to joining WVU in May, Doctor Benach served first as an Instructor at the University of Miami, then as Chief of Obstetrics and Gynecology in the State Public Health Department in Miami, Florida.

He is a Fellow of the American College of Obstetrics and Gynecology and has published 46 articles in scientific journals.

Dr. Glen P. McCormick, a native of Hinton, has joined the Division of Otolaryngology as Assistant Professor of Speech Pathology and Audiology.

Doctor McCormick earned B. A. and Masters degrees from WVU before receiving a Ph. D. degree in speech pathology and audiology from Purdue University in 1965. From 1964 to 1966, he served as speech pathologist and audiologist for the Louisiana State Board of Health.

Dr. Frank Crain has been transferred from the Department of Biochemistry to the Division of Medical Technology. In his new assignment, Doctor Crain is serving as Chief of the Chemistry Section of the Clinical Laboratories and Assistant Professor of Medical Technology. He holds Masters and Ph. D. degrees from WVU.

Dr. Anido To Lecture Abroad

Dr. Vicente Anido, Assistant Professor of Clinical Pathology, has been invited to present papers in Italy and Spain in October.

On October 6, he will present a paper on "Clinical Evaluation of a New Fluorimetric Procedure for Creatine Phosphokinase" at the Sixth International Congress of Clinical Pathology in Rome. On October 12, he will present a lecture on "Alterations of the Blood Cells in Leukemia—Before and After Treatment" at the School of Hematology at the University of Barcelona in Spain.

Mexico and Brazil Meetings

Four members of the School of Medicine faculty participated in meetings in Mexico and Brazil last month.

Dr. William W. Fleming, Chairman of the Department of Pharmacology; Dr. Alexander D. Kenny, Professor of Pharmacology; Dr. Richard D. Green III, Post-Doctoral Fellow in Pharmacology; and Dr. Richard J. Cenedella, Research Associate in Pharmacology, presented papers to the American Society for Pharmacology and Experimental Therapeutics in Mexico City, July 15-20.

Doctors Fleming and Kenny went on to Sao Paula, Brazil, where they presented papers before the Third International Pharmacological Congress, July 23-30.

Edits Medical Book

A book aimed at helping physicians in diagnosis has been edited by three persons, including a School of Medicine faculty member.

Dr. Rex. B. Conn, Jr., Associate Professor of Pathology, is one of the editors of "Current Diagnosis," which was published on June 1 by the W. B. Saunders Company. The other editors are Drs. Howard F. Conn of Uniontown, Pennsylvania, and Robert J. Clohecy of Smithfield, Pennsylvania.

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The Month in Washington

• From the Washington Office of the American Medical Association.

HEALTH manpower and medical research are being reviewed in two comprehensive studies being conducted by the federal government. President Johnson called on the new National Advisory Commission on Health Manpower for an evaluation of the use of available government and non-government health manpower. He also asked for commission recommendations on expanding the supply of health manpower.

"The national demand for health manpower today exceeds the supply— and this may be the case for several years," President Johnson told the commission. "This fact gives your job a special importance . . .

"First, I need your advice about the federal government's use of its health manpower:

—"Are we setting an example for the nation in the efficient use of health manpower?

—"Should we establish new forms of health manpower utilization?

"Second, we need answers to these same questions as they apply to non-federal health manpower.

"Third, we need your advice on how to develop additional health manpower—not only high-level specialists, but technicians and allied health professionals."

The Advisory Committee met for the first time a few days after the House unanimously passed and sent to the Senate a bill to train more health workers. The measure sets up a three-year, $155 million program of aid aimed at training some 12,000 additional allied health workers such as medical technologists, therapists, x-ray technologists, dental hygienists, nutritionists and laboratory technicians.

The legislation authorizes half the money for improving health worker training facilities and programs at qualified universities, colleges and junior colleges. The other half would go into a program of fellowship grants and federally guaranteed loans for students.

The bill also would authorize increased student loan forgiveness for physicians, dentists and optometrists who set up practice in poor rural areas where the supply of medical personnel is short or non-existent.

President Johnson instructed 23 Administration leaders in medicine and health matters, including Health, Education and Welfare Secretary John W. Gardner and the directors of the national health institutes, to reexamine their priorities to determine whether research activities should be slowed down and more effort devoted toward making practical use of research findings.

He asked for a report in a few months on a general reassessment of National Institutes of Health goals, effectiveness of current medical research programs, proportions of NIH funds being spent on basic research and on applied research, and major obstacles confronting the institutes in translating research findings into practical benefits.

The President was reported to have shown concern in a meeting with his top medicine and health advisors that too much is being spent "for the sake of research alone." Similar concern has been voiced by some non-government individuals knowledgeable in the health field.

National expenditures for medical research have increased from $87 million in 1947 to an estimated $1.85 billion last year. About two-thirds of the 1965 total was federal money and about four-tenths of the total was administered by the National Institute of Health. In the two decades following World War II, NIH annual appropriations have zoomed from $3 million to $1.25 billion. In recent years, Congress voted NIH more money than the Administration had requested.

"The National Institutes of Health are spending more than $800 million a year on biomedical research," President Johnson said. "I am keenly interested to learn not only what knowledge this buys but what are the payoffs in terms of healthy lives for our citizens . . ."

New Diet Food Regulations

The Food and Drug Administration has issued new regulations tightening the requirements for special diet food and diet supplements.

The revised regulations are aimed at providing the consumer with more facts about the foods for weight control, for dietary supplementation with vitamins and minerals, and for other special diet needs, such as controlling salt intake, according to Dr. James L. Goddard, the head of FDA.

The new regulations set standards for certain foods to which nutrients may be added only if they have real value. A Recommended Dietary Allowances also is included as a guide to meeting nutritional needs.

The new regulations will prohibit extravagant promotion of "shotgun'" multi-vitamin and mineral supplements containing nutrients that meet no dietary need and tend to deceive the consumer.

The revised labeling regulations and the new standards for fortified foods and vitamin and mineral supplements are scheduled to become effective in December.

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Obituaries

WILLIAM HARRY BOONE, M. D.

Dr William H. Boone of Keyser died suddenly on July 2 at his home. He was 70.

A native of Winona, Doctor Boone had been a radiologist at Potomac Valley Hospital in Keyser since early in 1963. He attended West Virginia University and received his M. D. degree in 1919 from Western Reserve University School of Medicine.

Doctor Boone interned at Cleveland City Hospital in Cleveland and at Harper Hospital in Detroit. He served a residency at University Hospital in Ann Arbor, Michigan.

From 1930 to 1947, he was Director of Radiology at Roosevelt Hospital in New York City. While located in New York, he served as President of the New York Roentgenology Society.

Doctor Boone was a Diplomate of the American Board of Radiology and was a member of the American College of Radiology and the American Roentgenology Society of North America.

His other professional memberships included the Potomac Valley Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow, Mrs. Eve Boone; a son, William H. Boone, Jr., of New York City; three sisters, the Misses Io and Neva Boone of Lewisburg, and Mrs. Archbold Jones of Parkersburg; and one grandchild.

* * * *

CARL JOHN CARTER, M. D.

Dr. Carl J. Carter, 74-year-old Fairmont surgeon, died on June 9 after a brief illness.

A native of Mt. Harmony, Doctor Carter attended Fairmont State Normal School and West Virginia University before receiving his M. D. degree in 1924 from the Medical College of Virginia.

Before finishing his medical education, Doctor Carter served as a Captain in the Field Artillery during World War I. He was a Fellow of the American College of Surgeons and was a member of the International Academy of Medicine, the Marion County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Doctor Carter served as Superintendent of Fairmont Emergency Hospital from 1957 to 1961 under appointment by former Gov. Cecil H. Underwood.

Survivors include the widow, Mrs. Laura Carter; a daughter, Mrs. Leonard Sargeant III of Charleston; two grandchildren; and a brother, Allen E. Carter of Winchester, Virginia.

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EDWARD L. JUSTICE, M. D.

Dr. Edward L. Justice, 61, died at his home in Weirton on June 22. He had been in failing health for several years.

Doctor Justice was born in Mingo Junction, Ohio, and practiced there for about five years before locating in Weirton in 1939. He attended West Virginia University and received his M. D. degree in 1932 from Emory University School of Medicine.

He was a member of the Hancock County Medical Society, the Fort Steuben Academy of Medicine, the West Virginia State Medical Association, the Southern Medical Association, the American Medical Association and the American Academy of General Practice.

Survivors include the widow, Mrs. Jean Neel Justice; two sons, Edward, Jr., of Portage, Indiana, and Charles W. Justice of Fort Pierce, Florida; a daughter, Mrs. Curtis Carlson of Chicago; two sisters, Mrs. Bertha J. Peck of Steubenville, Ohio, and Mrs. Mae Johnson of Hollywood, California; and five grandchildren.

* * * *

WILLIAM FRANK McFARLAND, M. D.

Dr. William F. McFarland, who formerly practiced medicine in Keyser, died on June 2 in a hospital in Billings, Montana. He was 54.

Doctor McFarland had undergone a kidney transplant last December at the Cleveland Clinic Hospital, and it was understood that he had since resumed practice at his offices in Billings and Hardin, Montana.

A native of Keyser, Doctor McFarland attended Potomac State College and West Virginia University. He received his M. D. degree in 1936 from the Medical College of Virginia. He maintained a practice in Keyser for several years up to 1950.

He was a former member of the Potomac Valley Medical Society and the West Virginia State Medical Association.

Survivors include the widow, Mrs. Maxine McFarland; the mother, Mrs. Josephine McFarland of Keyser; four children by a previous marriage; a stepson; and a brother, Charles H. McFarland of Annapolis, Maryland.

Second Look at New Drug Laws?

Many economists are convinced that the American system of patents and trademarks and brand names has been a vital factor in the great progress of the United States and its leadership in establishing a standard of living superior to that anywhere else in the world.

The factors involved include not only this system but also the right to advertise, the right to disseminate information, and the right to legitimate pride in distributing as widely as possible the benefits of new inventions and discoveries. How much time must pass before the ultimate effects of the new (drug) legislation become apparent is difficult to predict. The effects are only beginning to be felt. Perhaps the time is near when the legislators will have to take a second look.—Morris Fishbein, M. D., in *Postgraduate Medicine*.

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County Societies

B-R-T

Dr. Robert J. Marshall of Morgantown was guest speaker at a meeting of the Barbour-Randolph-Tucker Medical Society which was held on May 19 at Blackwater Lodge.

Doctor Marshall discussed "Recent Advances in Cardiology." He talked on cardioversion by electroshock and the use of the pacemaker in the treatment of Stokes-Adams Syndrome.

Dr. Evangeline M. Poling of Philippi was elected President of the Society for the coming year. Other new officers are: Dr. S. M. Lilienfeld of Parsons, First Vice President; Dr. Robert R. Rector of Elkins, Second Vice President; Dr. Guy H. Michael, Jr., of Parsons, Treasurer; and Dr. A. Kyle Bush of Philippi, Secretary.

The Society approved a mass measles vaccine clinic for Randolph County.—A. Kyle Bush, M. D., Secretary.

★ ★ ★ ★

MARION

Dr. David Bressler of Fairmont was elected President of the Marion County Medical Society during a meeting in Fairmont on June 8.

Other officers of the Society for the coming year are: Dr. Delbert C. Smith of Fairmont, Vice President; Dr. G. Thomas Evans of Fairmont, Secretary; and Dr. Robert R. Frye of Mannington, Treasurer.

★ ★ ★ ★

McDOWELL

Mr. R. N. Campbell of Charleston was guest speaker at the regular monthly meeting of the McDowell County Medical Society which was held in Welch on June 29.

Mr. Campbell is Nationwide Insurance Company's Medicare Manager for West Virginia. He described his company's role as fiscal intermediary under Part B of the Medicare Program.

More than 20 physicians and visitors attended the meeting.—John S. Cook, M. D., Secretary.

★ ★ ★ ★

PRESTON

Dr. Seigle W. Parks of Charleston, President of the West Virginia State Medical Association, addressed a joint meeting of the Preston County Medical Society and the Preston County Bar Association in Kingwood on June 23.

Doctor Parks spoke on "Medicare."

More than 35 members of the two organizations and their guests attended the dinner meeting at the Preston Country Club.

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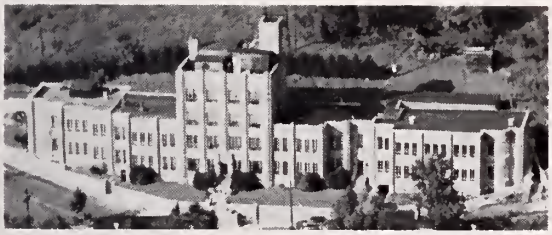
HARRISON

Mrs. Albin A. Galuszka of Clarksburg was installed as President of the Woman's Auxiliary to the Harrison County Medical Society during a program at the Stonewall Jackson Hotel in Clarksburg on May 5.

Mrs. L. Dale Simmons of Clarksburg also installed the following new officers:

Mrs. Hugh M. Brown of Clarksburg, President Elect; Mrs. Robert S. Wilson of Clarksburg, Vice President; Mrs. Phillip W. Hall of Clarksburg, Secretary; and Mrs. E. Burl Randolph of Clarksburg, Treasurer.

A Chinese auction was conducted for the benefit of AMA-ERF.—Mrs. James E. Wilson, Jr.



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Book Reviews

QUESTIONS AND ANSWERS—Published by the American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

This small book of selected questions and answers that have appeared in the AMA Journals of 1965 makes interesting reference. The book is divided into 37 sections with reference to all things from allergy to urology. All subjects are listed in the alphabetical index. This is not a medical encyclopedia but if you have a problem somewhat similar to one of the questions, you will receive an answer from one or two experts. This might give you more information than you could find in a prolonged search of the literature.

* * * *

MEDICAL SERVICE IN THE MEDITERRANEAN AND MINOR THEATERS—By Charles M. Wiltse, Chief Historian, Office of the Chief of Military History, Department of the Army, Walter Reed Army Medical Center, Washington, D. C.

This volume, the second to be published in the subseries, the Technical Services in World War II, relates the activities, location and deployment of all medical units in stated areas. Most of the volume concerns military medicine in the Mediterranean Theatre.

Almost all the general hospitals of the Mediterranean Theatre were affiliated with medical schools or civilian hospitals and had the highest level of professional personnel. Many evacuation hospitals were staffed by personnel from a particular medical school or hospital. The station hospitals were relatively fixed in location and staffed with professional men and women who had been selected with the utmost care and with regard to a particular skill. It is unlikely that up to 1942-45 any military campaign had hospital service equal to the excellence of the Mediterranean Theatre of Operation.

The line of communication from battlefield to hospital was unusually rough in Sicily and Italy but the Medical Corps usually resolved the problem reasonably satisfactorily.

Much of the medical and surgical excellence can be attributed to area consultants, Col. Edward E. Churchill and Col. Perrin H. Long. The battlefield treatment of acute psychoneurosis, according to the program of Col. Fred Hareson, emerged as one of the outstanding medical accomplishments of the war.

Historians will debate forever the strategic value of the Italian Campaign and the Anzio invasion but no one can dispute the excellence of the medical services provided in this theatre of operation.

The reviewer has searched this volume for any indication of the university or hospital affiliation of any unit and although many tables, appendices, etc. are present, there is no reference to the civilian medical structures that developed these fine hospitals.

It is true that upper echelon administration came from the Regular Army. It also is true that the high

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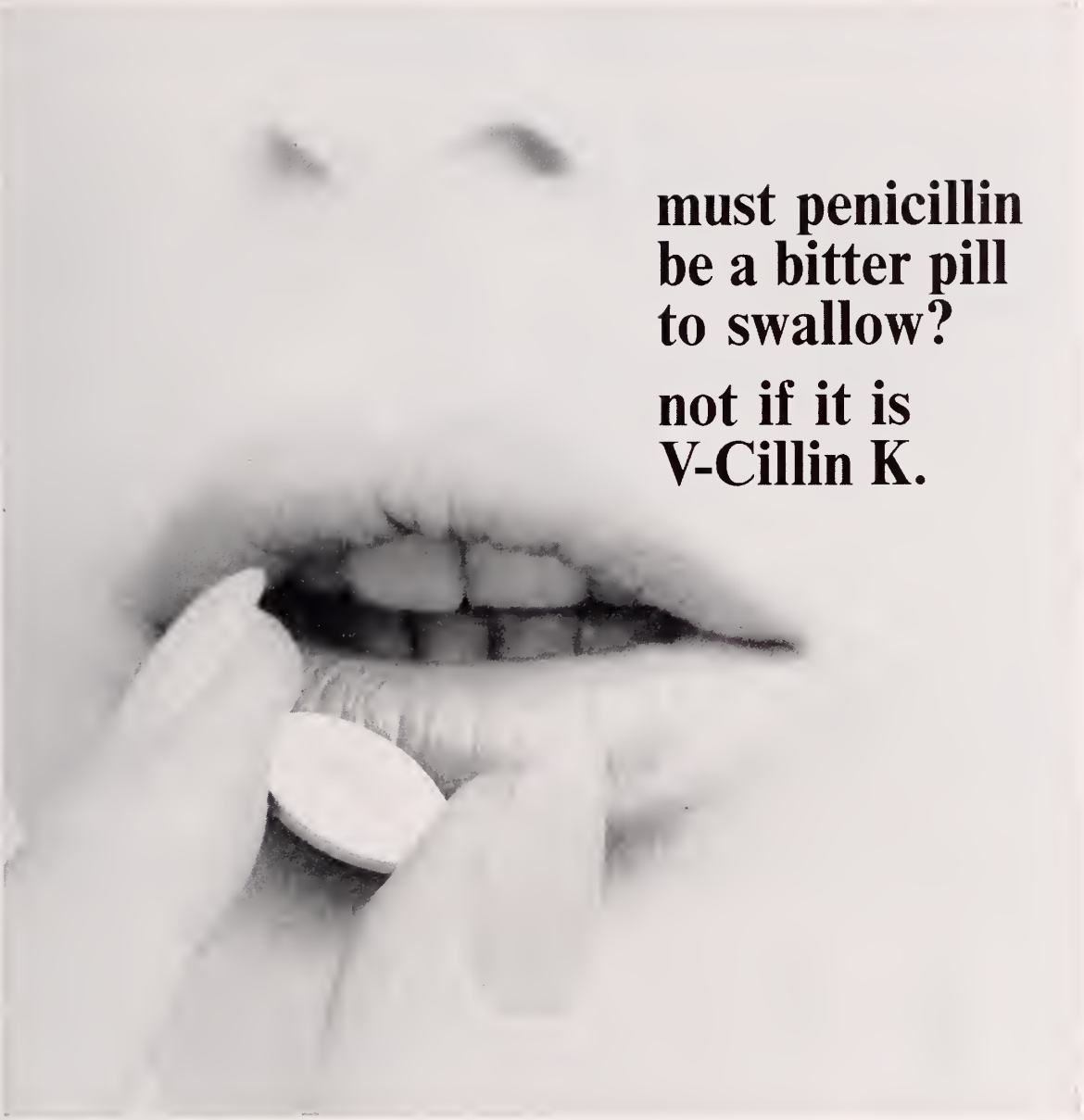

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level of medical service of the Mediterranean operation resulted from the activities of civilian doctors in uniform.

* * * *

PREIMPLANTATION STAGES OF PREGNANCY—Ciba Foundation Symposium. Edited by C. E. W. Wolstenholme and Maeve O'Connor. Little Brown and Company; Boston. 1965. Pp. 430, with 153 illustrations. Price: $13.50.

The symposium on "Preimplantation Stages of Pregnancy" was organized to cover a broad area of experimental work over a short period of embryonic development, including chemical, structural and environmental components. This book covers the period of early zygotic development (almost exclusively rodents), which includes sperm penetration to implantation. Ultra-structure, energy metabolism and synthesis of nucleic acid and proteins during preimplanation stages were discussed. A good portion of the work involved the techniques of *in vitro* culture of fertilized ova and of ova transfer.

Environmental effects of the oviduct, uterus and *in vitro* cultures were covered as well as effects of irradiation. Also, studies of developmental potential of isolated blastomeres and of fused zygotes were presented.

This is a very useful book for persons working with early stages of zygotes and gives a good review of work in this field. It is doubtful, however, if many physicians would be interested in this book.—Roy L. Butcher, Ph.D.

PMA Says Drug Prices Holding Line

Recent evidence shows that prescription drug manufacturers have been holding the line on prices despite nationwide inflationary pressures, according to the Pharmaceutical Manufacturers Association.

PMA, in a recent announcement, said figures through 1965 indicate a drop in wholesale prices for prescription products averaging one per cent a year since 1961.

Drugs covered by patents have shown an even more consistent drop—eight per cent during the same period, the PMA said. Non-patented items have had an increase of slightly more than two per cent.

The PMA index measures price changes back to 1949. Since then, antibiotics have held a runaway lead in wholesale drug price level reductions, averaging more than 62 per cent lower in 1965 than in 1949.

PG Course in Industrial Medicine

The Mound Park Hospital Foundation in St. Petersburg, Florida, will conduct a postgraduate course entitled "Industrial Medicine: The Doctor's Role in Occupational Health," October 20-22.

The program is acceptable for 18 accredited hours by the American Academy of General Practice.

Additional information may be obtained by writing to Dr. M. A. Barton, President, Mount Park Foundation, Inc., St. Petersburg, Florida 33701.

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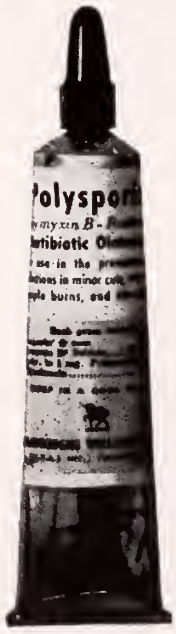

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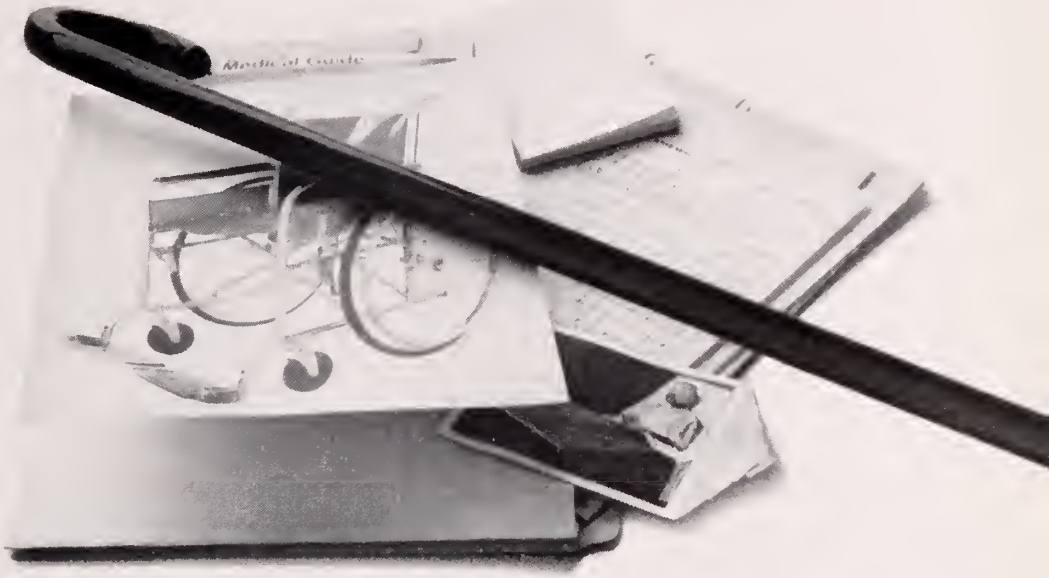

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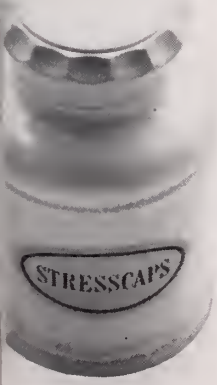

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PG Course in Laryngology

The Department of Otolaryngology of the Illinois Eye and Ear Infirmary and the College of Medicine of the University of Illinois at the Medical Center, Chicago, will conduct a postgraduate course in Laryngology and Bronchoesophagology, October 31 to November 12. Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Additional information may be obtained by writing to the Department of Otolaryngology, College of Medicine of the University of Illinois at the Medical Center, P. O. Box 6998, Chicago, Illinois 60680.

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35th Annual Meeting of AAP In Chicago

A diverse scientific program has been arranged for the 35th Annual Meeting of the American Academy of Pediatrics which will be held at The Palmer House in Chicago, October 22-27.

More than 4,500 pediatricians and their families and guests are expected to attend the meeting.

The scientific program will feature discussion of such subjects as growth hormone and disorders of growth, intrauterine growth retardation, and clinical trial of live attenuated rubella virus vaccine. Additional subjects to be covered include the unmet needs of children, pediatric practice—increasing the effectiveness of office practice, urinary tract infections, diagnostic procedures in intestinal disease, and language development and disorders.

The Academy meeting is open to physicians who are not pediatricians. Registrations fees are $16 for Academy members, applicants to the Academy and the American Board of Pediatrics, non-members out of school less than five years, and physicians in the Armed Forces. Registration for non-members out of school more than five years is $50.

Further information is available at the American Academy of Pediatrics, 1801 Hinman Avenue, Evanston, Illinois 60204.

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SEPTEMBER
1966

Vol. 62 No. 9

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Official Organ of the West Virginia State Medical Association

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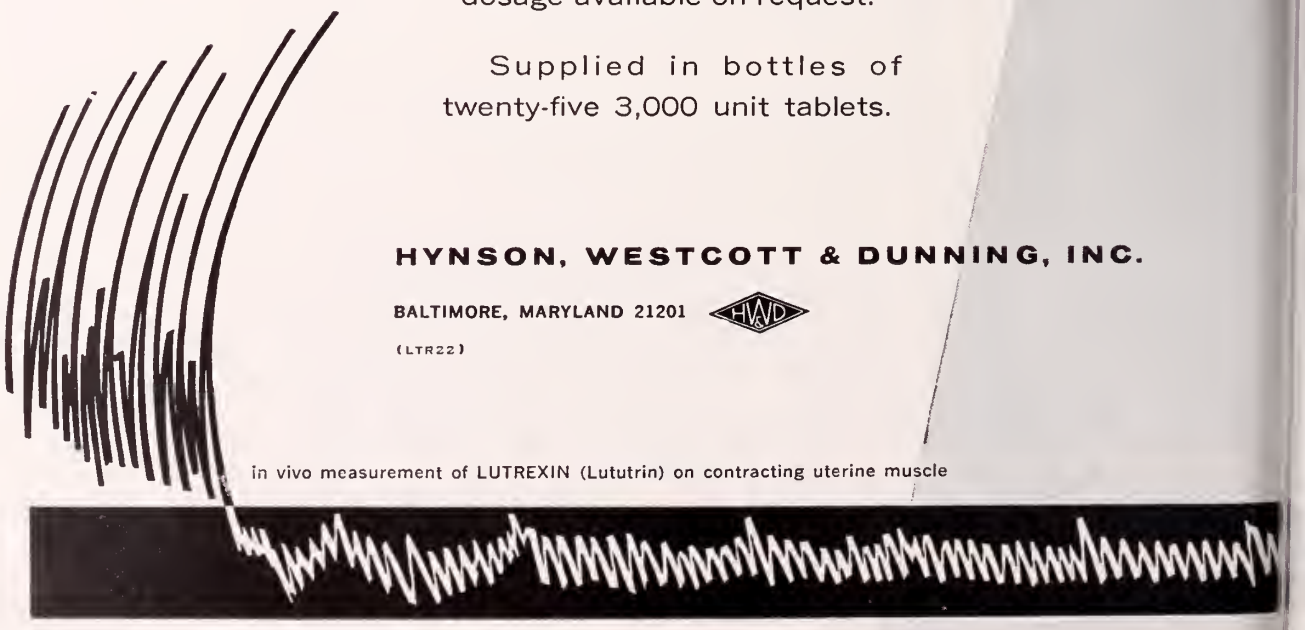

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WVU Medical Center
—News—

• **Compiled from material furnished by Arthur V. Ciervo, Director, Medical Center News and Information Services, Morgantown, West Virginia.**

West Virginia University has received a $500,000 gift to establish a Margaret Higgins Sanger Chair of Family Planning and Reproductive Physiology in the School of Medicine's Department of Obstetrics and Gynecology.

The gift was made by Mrs. Cordelia Scaife May of Ligonier, Pennsylvania. Mrs. May for many years has been interested in the many problems resulting from the almost unrestricted population growth throughout the world.

Occupying the chair is Dr. Walter A. Bonney, Jr., who has been serving as Acting Chairman of the Department of Obstetrics and Gynecology at Vanderbilt University School of Medicine. At WVU, he holds the academic rank of Associate Professor.

In commenting on the appointment of Doctor Bonney, Dr. Nicholas W. Fugo, Chairman of the Department of Obstetrics and Gynecology, described him as "one of the most outstanding young men in the field of obstetrics and gynecology."

Doctor Bonney, a native of Mississippi, received his M. D. degree in 1954 from the College of Physicians and Surgeons of Columbia University.

Faculty Appointments

Several additional appointments to the School of Medicine faculty were made in July. They include:

Dr. Murray C. Brown of Kensington, Maryland, was appointed Clinical Professor of Medicine. Doctor Brown, a native of Washington, D. C., received his M. D. degree from the University of Virginia School of Medicine and once served as director of the Venereal Disease Control Program in Logan County.

Dr. Cuvier D. McClure of New York City, who until recently was associated with the Public Health Service Region II Chronic Disease Program, was named Associate Professor of Medicine. Doctor McClure received his M. D. degree from the University of Colorado School of Medicine, and holds masters and doctorate degrees in public health from the University of Pittsburgh. He is a native of Colorado.

Named Instructors in Internal Medicine were Drs. Kenneth C. Kaplan of Hohokus, New Jersey; N. LeRoy Lapp of Rochester, Minnesota; and A. David Russakoff of Kew Gardens, New York.

Doctor Kaplan, who was born in New York City, received his medical degree from New York University and served there until this year as Instructor in Physical Diagnosis.

Doctor Lapp is a native of Perkasie, Pennsylvania, and received his M. D. degree from Temple University. Before joining WVU, he was a resident in internal medicine at the Mayo Graduate School, University of Minnesota.

Doctor Russakoff received his M. D. degree from Tufts University. He came to WVU from an internal medicine residency at the Veterans Administration Hospital in Dallas, Texas.

Dr. Juro Iriuchijima will serve as Visiting Associate Professor of Physiology for one year. He holds an M. D. degree and a Ph. D. degree in physiology from the University of Tokyo, where he has been serving as Associate Professor of Physiology.

Dr. Peter Halmos became an Instructor in Internal Medicine. He received his M. D. degree last year from Queen's University in Northern Ireland.

Dr. Judith R. Hildebrandt, a native of Detroit, Michigan, becomes Assistant Professor of Physiology. She holds a Ph. D. degree from the University of Washington.

Dr. Charles R. Craig, a native of Buckhannon, was appointed to an assistant professorship in the Department of Pharmacology. He earned his Ph. D. degree in pharmacology from the University of Wisconsin in 1964.

Coronary Drug Project

The Medical Center will participate in a Coronary Drug Project, one of the largest investigations of its kind ever carried out in American medicine.

The research will involve 8,000 patients, about 200 of them at the Medical Center, where Dr. David Z. Morgan is principal investigator for the five-year project.

Doctor Morgan said the Medical Center is looking for males between the ages of 30 and 65 who have suffered heart attacks and who are willing to make periodic visits to the Out-Patient Department for care and studies throughout the five-year period. Drugs, elaborate laboratory studies and medical treatment will be given free of charge.

Purpose of the study is to determine the effectiveness of four drugs which have been used in the treatment of coronary heart disease.

Anyone wishing to participate is asked to contact Doctor Morgan.

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The Month in Washington

• From the Washington Office of the American Medical Association.

THE Public Health Service Advisory Committee on Immunization has concluded that routine typhoid fever vaccination is not needed any longer in the United States. Surgeon General William H. Stewart accepted the findings of the committee and stated as PHS policy that immunization against the disease is not recommended on a routine basis.

The committee reported that the incidence of typhoid in this country had declined steadily for many years and now is less than 500 cases a year. A continuance of the downward trend was predicted.

"Cases are sporadic and are primarily related to contact with carriers rather than to common source exposure," the committee said. "Recognizing this epidemiologic pattern of typhoid fever, redefinition of the role and use of typhoid vaccine is indicated."

The committee further stated that, "although typhoid vaccine has been suggested for individuals attending summer camps and those in areas where flooding has occurred, there are no data to support the continuation of these practices."

However, select immunization was recommended in the following situations:

—Intimate exposure to a known typhoid carrier as would occur with continued household contact.

—Community or institutional outbreaks of typhoid fever.

—Foreign travel to areas where typhoid fever is endemic.

In a separate report, the advisory committee preicted relatively little influenza during the 1966-67 season, but recommended vaccination after September 1 for certain high-risk groups—such as the chronically ill and older persons.

The committee pointed out, however, that it is reasonable to expect that limited outbreaks of Type A_2 influenza will occur in parts of the United States not experiencing Type A disease in 1964-65 or 1965-66. Similarly, the possibility of some Type B influenza is recognized, particularly in the Southwest.

"Vaccination when called for should begin as soon as practicable after September 1 and ideally should be completed by mid-December," the committee said. "It is important that immunization be carried out before influenza occurs in the immediate area since there is a two-week interval before development of antibodies."

Because variations in influenza viruses during the 1965-66 season were not of major significance, the composition of the 1966-67 vaccine is unchanged from that prepared for 1965-66.

Use of Pesticides

A Senate Government Operations Subcommittee said that more information is needed in the field but that scientific data now available does not indicate human health hazards of sufficient significance to warrant drastic curbs on the use of pesticides.

The subcommittee reported, however, that "the magnitude of the future risk is uncertain in many important areas."

"Knowledge regarding the risk of chemical pesticides . . . will have to be broadened and refined considerably in order to provide clear-cut answers to questions that will be forced by the increasing need for pest control in the future," said a subcommittee report based on a two-year study.

"While some of the more gloomy prophecies that had been raised could not be supported by hard scientific fact, it is also true that science could not and still cannot prove that some of these prophecies are untenable."

To combat the human health dangers, the report recommended that the Department of Health, Education and Welfare, accelerate an environmental health program; increased research in human pharmacology; development of safer chemical pesticides which are safer for human beings; greater emphasis on development of non-chemical pest-control methods; training of agricultural workers in good hygiene practices in using pesticides; and general educational programs on health in the chemical age.

'Dietary Fat and Human Health'

The Food and Nutrition Board of the National Academy of Sciences believes that it may be well for many Americans to moderately reduce the amount of fats they eat and substitute some polyunsaturated for saturated fats.

However, the board concluded in a lengthy report, "Dietary Fat and Human Health," that present evidence on the connection between dietary fat and cardiovascular diseases is insufficient to warrant recommendations for radical dietary changes.

The board's study was directed to the problem of how much and what kind of fat is compatible with human health. The report emphasized that any changes in consumption of fat should be made on an individual basis with consideration given the consequent changes in caloric and nutrient intake.

Anatomy of
Low Back Pain #1

the sedentary life is often the seat of low back pain

The human spine is not engineered for prolonged sitting at desks, pianos, typewriters and drafting boards. The stresses set up by the heavy, forward-tilted head and trunk, balanced precariously on an insufficient base, result in strain of the dorsal musculature, particularly at the low lumbar level.

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Contraindications: Allergic or idiosyncratic reactions to carisoprodol.

Precautions: 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

Side Effects: The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

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Obituaries

JOHN MADISON COFER, M. D.

Dr. John M. Cofer, 82, died at his home in Webster Springs on July 20.

A native of Bedford County, Virginia, Doctor Cofer attended the College of William and Mary and received his M. D. degree in 1913 from the Medical College of Virginia.

Doctor Cofer was an honorary member of the Central West Virginia Medical Society, of which he once served as Secretary; the West Virginia State Medical Association; and the American Medical Association.

He was a member and past president of the Webster County Court and a member of the Webster County Board of Education.

Survivors include two sons, Everette E. of Eldorado, Arkansas, and Lt. Col. John Madison Cofer, who is stationed with the U. S. Army in France; two brothers, Clyde of Mount Clare and Robert of Roanoke, Virginia; and a sister, Miss Ella Lee Cofer of Montvale, Virginia.

* * * *

NEVINS BYFORD HENDRIX, M. D.

Dr. N. B. Hendrix died in a Martinsburg hospital on August 1 after a long illness. He was 76.

A native of Lexington, South Carolina, Doctor Hendrix had practiced surgery in Martinsburg since 1932. He attended Newberry College in South Carolina and received his M. D. degree in 1926 from the University of Maryland Medical School. He also held B. A., M. A., and Ph. D. degrees.

Doctor Hendrix was an honorary member of the Eastern Panhandle Medical Society, which he served as President in 1942; the West Virginia State Medical Association and the American Medical Association. He was a Fellow of the American College of Surgeons.

Survivors include the widow, Mrs. Pearl Grant Hendrix; two sons, Nevins B. Hendrix, Jr., and Charles N. G. Hendrix, both of Shepherdstown; one sister, Mrs. Rosalia Abel of Leesville, South Carolina; and one grandchild.

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Side effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
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County Societies

CABELL

Dr. Jack Winestock, a New York City urologist and playwright, was guest speaker at the regular monthly meeting of the Cabell County Medical Society which was held at the Hotel Frederick on June 9.

Doctor Winestock described his experiences, including the writing of the Broadway hit, "How to Succeed in Business Without Really Trying."

Dr. John David Pitsenberger was elected unanimously to membership in the Society.

Eighty-eight members and guests attended the meeting.—Harold N. Kagan, M. D., Secretary.

* * * *

CENTRAL WEST VIRGINIA

Thirty members, wives and guests attended the July meeting of the Central West Virginia Medical Society, which was held in Richwood.

Dr. John E. Echols of Richwood was in charge of arrangements for the meeting, which featured a cook-out.

The speaker for the meeting was unavoidably detained elsewhere, and the group spent the evening discussing Medicare and other current medical topics.

MONONGALIA

Four members of the Resident Staff of West Virginia University Hospital presented papers at the regular monthly meeting of the Monongalia County Medical Society which was held on June 7.

Presenting papers were Drs. Schrae La Plante, Arsenio Orteza, George Cueto and Ben Plyboy.

Thirty-five members and guests attended the meeting.—Robert Greco, M. D., Secretary.

BS Members, Payments Reach New High

Blue Shield membership and benefit payments both reached record highs during 1965, while operating expenses fell to a new low, according to the 1965-66 Annual Report of the National Association of Blue Shield Plans.

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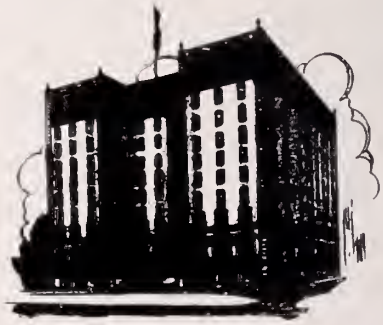

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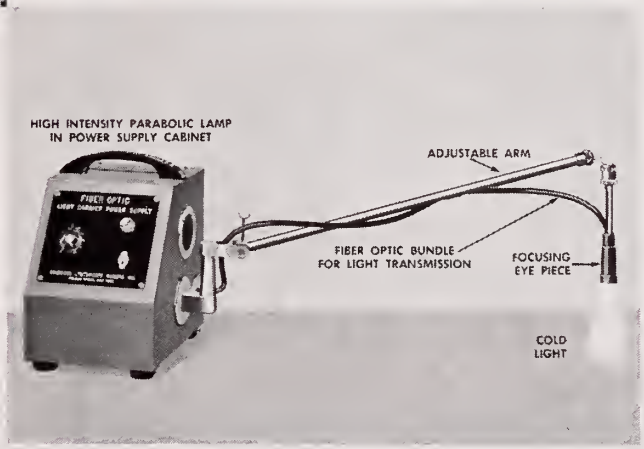

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Medical Aspects of Sports Meeting in Las Vegas

The Eighth National Conference on the Medical Aspects of Sports will be held in Las Vegas, Nevada, on November 27 in conjunction with the Clinical Convention of the American Medical Association.

The conference will cover a wide range of subjects of interest to those serving school and college athletic programs. Included will be forums and discussion sections relating to criteria for immediate management of knee injuries, resources for grass roots supervision of sports, medical preparations for international competitions and the relationship of athletic fitness to physical fitness.

Speakers will include Dr. Merritt Stiles, Second Vice President of the U. S. Olympic Committee; Dr. Donald O'Donoghue, President of the American Academy of Orthopedic Surgeons; and Dr. Robert S. Roche, Medical Examiner for the California State Athletic Commission.

Doctor Roche will speak at the conference luncheon.

The conference is held annually on the first day of the AMA Clinical Convention.

The conference is open to key nonmedical athletic personnel as well as interested physicians. Requests for additional information should be addressed to Secretary, Committee on the Medical Aspects of Sports, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Congress on Medical Quackery In Chicago, Oct. 7-8

The Third National Congress on Medical Quackery will be held at the Pick-Congress Hotel in Chicago, October 7-8, under the sponsorship of the American Medical Association and the National Health Council.

The Congress will be based on the theme of "Quackery: 1966" and will be aimed at calling to the nation's attention the perils posed by present-day fads and fallacies in the health field.

Each of the two earlier congresses was attended by more than 600 persons interested in medical quackery, representing the fields of education, government, and professional and voluntary organizations. Between 750 and 1,000 persons will be invited to the Third Congress.

Inquiries should be addressed to Dr. John G. Thomsen, Chairman, Committee on Quackery, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

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Book Reviews

CURRENT DIAGNOSIS—By Howard F. Conn, M. D., Robert J. Clohecy, M. D., Rex B. Conn, Jr., M. D. W. B. Saunders Company, Philadelphia, London. Pp. 843. Illustrated. 1966. Price: $19.00.

This is a biennial volume of clinical diagnostic methods and evaluation by a multitude of prominent authors from the United States, Canada, Mexico and abroad. It is divided into 19 sections representing the systems, specialties, etc., and ending with a 20-page section on Disease of Unknown Causes—which might indicate that there are but a few diseases that do not have a predetermined etiology.

The preface states the purpose—"an effort to provide the physician with an authoritative source of information in today's best and most up-to-date methods of arriving at a precise understanding of the nature of a patient's illness—to assist the physician to cope with the most difficult problems in medicine; the patient without atypical symptoms; with misleading signs."

The index is 68 pages of fine print in three column pattern and is extremely complete for all signs and complaints.

The general arrangement follows as far as possible this pattern; definition, signs, symptoms, cause, physical

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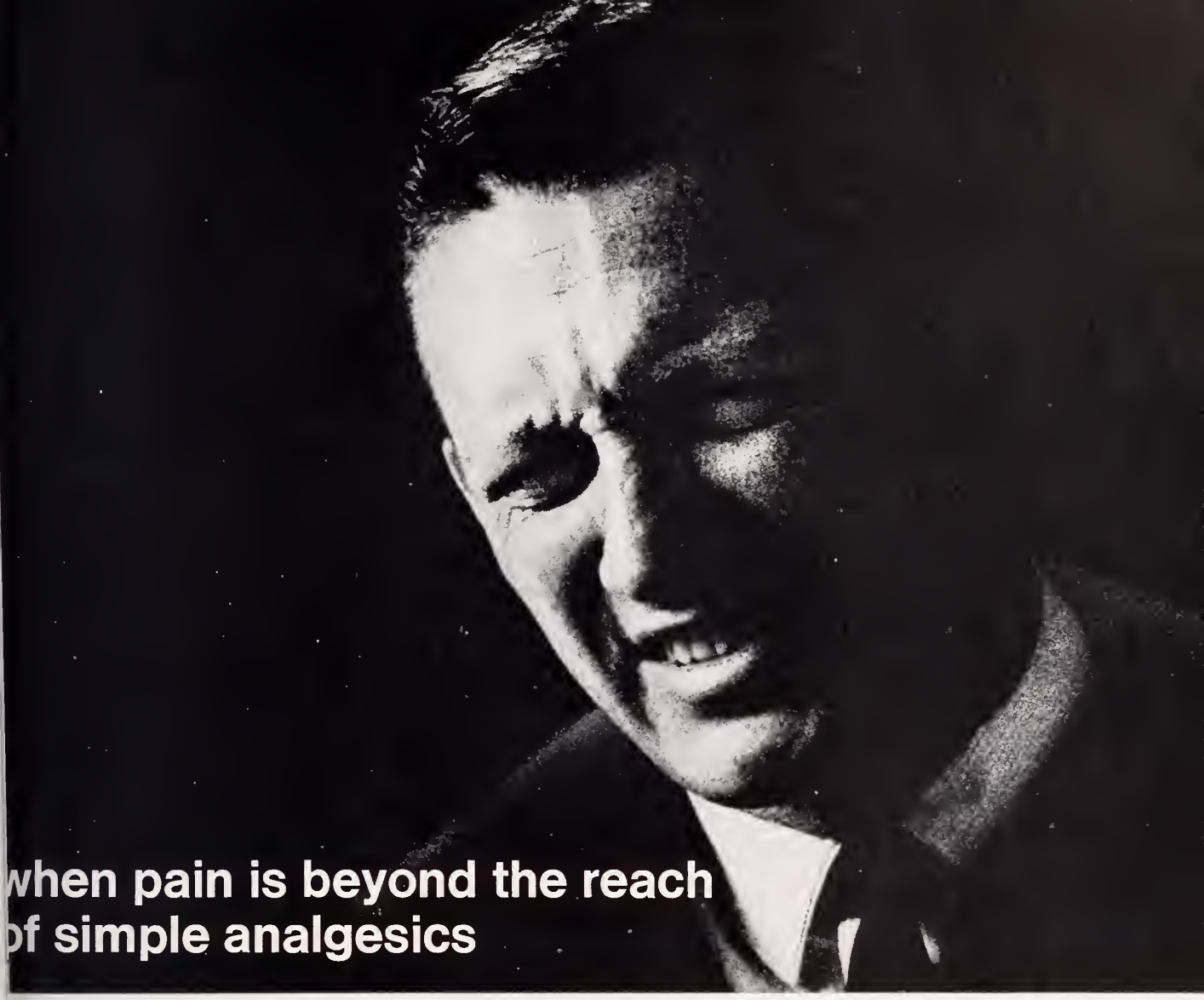

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Cabell	Joseph M. Farrell	Huntington	Harold N. Kagan	Huntington	2nd Thurs.
Central West Virginia	Charles T. Lively	Weston	R. L. Chamberlain	Buckhannon	As Scheduled
Eastern Panhandle	C. Vincent Townsend	Martinsburg	Frank J. Gavlas	Martinsburg	2nd Wed.
Fayette	Thomas Kerr Laird	Montgomery	William L. Claibarne	Montgomery	1st Wed.
Greenbrier Valley	Stuart T. Bray	White Sulph. Springs	Arnold J. Brody	White Sulph. Sprgs.	2nd Wed.
Hancock	Eli J. Weller	Weirton	Dominic A. Brancazio	Weirton	2nd Tues.
Harrison	James A. Thompson	Clarksburg	E. Leon Linger	Clarksburg	1st Thurs.
Kanawha	George R. Callender, Jr.	Charleston	Ernest Q. Hull	South Charleston	2nd Tues.
Logan	Kwan Ha Lee	Logan	Mark S. Spurlock	Logan	2nd Wed.
Marion	Robert J. Sidow	Fairmont	G. Thomas Evans	Fairmont	Last Tues.
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Mason	C. Leonard Brown	Pt. Pleasant	Dan Glassman	Pt. Pleasant	Bi-Monthly
McDowell	Charles F. McCord	Welch	John S. Cook	Welch	2nd Wed.
Mercer	Thomas B. Baer	Bluefield	John J. Mahood	Bluefield	3rd Mon.
Mingo	Alexander M. MacKay	Williamson	L. Lake Swigart	Williamson	2nd Wed.
Monongalia	Lawrence S. Miller	Morgantown	Robert Greco	Morgantown	1st Tues.
Ohio	James C. Hazlett	Wheeling	John Battaglino, Jr.	Wheeling	4th Tues.
Parkersburg Academy	Fay P. Greene, Jr.	Parkersburg	Charles H. Barnett	Parkersburg	1st Thurs.
Potomac Valley	Phillip G. Staggers	Keyser	Clinton L. Rogers	Keyser	2nd Wed.
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Vol. 62 No. 10

The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Assaciatian

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Member 1966

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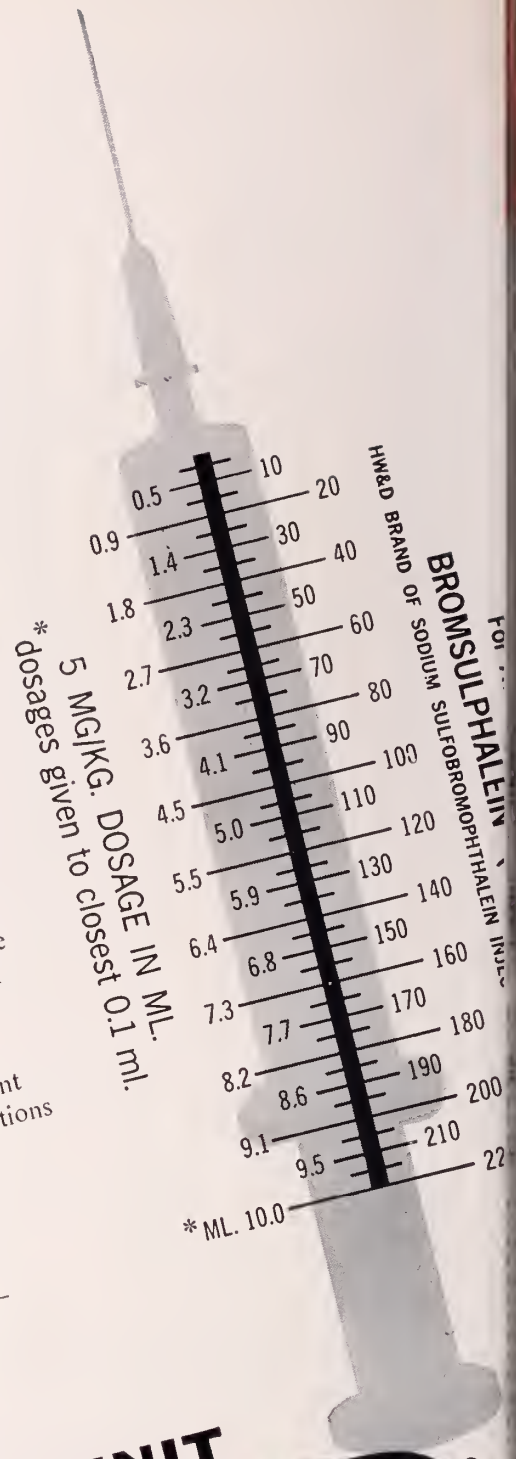

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rences: (1) Based on 23 clinical papers, 1512 cases. Bibliography on est. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: nicrobial Agents and Chemotherapy—1964, Ann Arbor, American ety for Microbiology, 1965, p. 722.

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County Societies

HARRISON

Dr. Richard E. Flood of Weirton, President of the West Virginia State Medical Association, was guest speaker at the regular monthly meeting of the Harrison County Medical Society, which was held in Clarksburg on September 1.

Dr. Richard V. Lynch, Jr., of Clarksburg, President Elect of the Association, introduced Doctor Flood, who gave an interesting and informative talk on the problems facing the Association and programs he advocates. It was Doctor Flood's first appearance at a component society meeting as President.

After the meeting, members and guests attended a reception in honor of Doctor Flood at the home of Dr. and Mrs. James A. Thompson.—E. L. Linger, M. D., Secretary.

* * * *

McDOWELL

The regular monthly meeting of the McDowell County Medical Society was held at Stevens Clinic Hospital on September 14.

Dr. A. J. Villani reported to the Society on the actions of the House of Delegates during the 99th Annual Meeting of the West Virginia State Medical Association.

Dr. A. A. Carr, Chairman of the Entertainment Committee, announced that the Society will have a supper-dance at Gary Country Club on December 17.

Twelve members and guests attended the meeting.—John S. Cook, M. D., Secretary.

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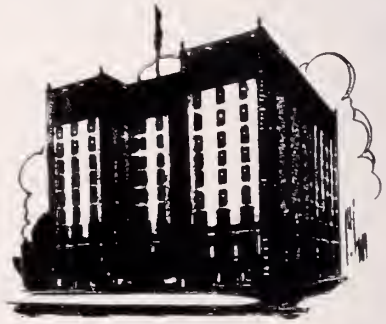

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EASTERN PANHANDLE

The Woman's Auxiliary to the Eastern Panhandle Medical Society held a coffee hour and meeting at the home of Dr. and Mrs. John H. Kilmer in Martinsburg on August 31.

Mrs. D. Ewell Hendricks, the President, made a report on the annual meeting of the Woman's Auxiliary to the West Virginia State Medical Association, which was held in White Sulphur Springs in August.

Preliminary plans were made for entertaining wives of physicians who will attend the annual Potomac-Shenandoah Valley Postgraduate Institute in Martinsburg in late October. Mesdames L. Walter Fix and E. Walter Rice are Co-Chairmen of arrangements.

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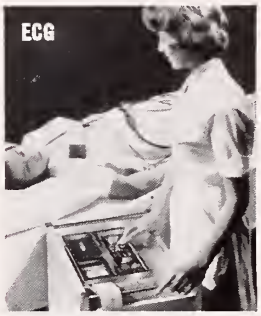

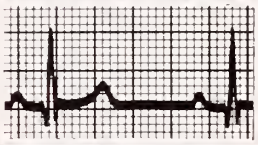

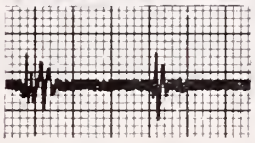

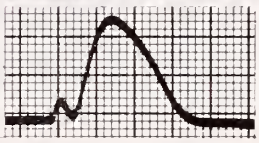

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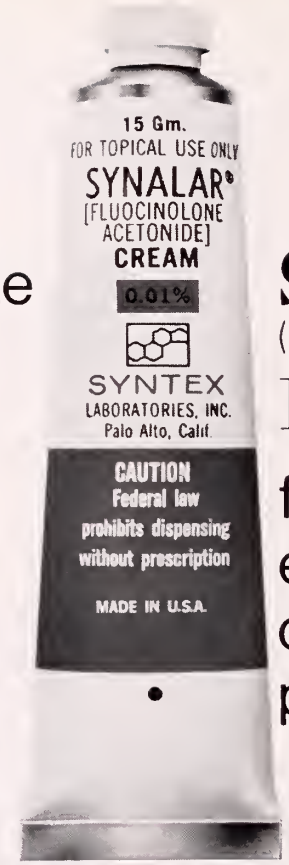

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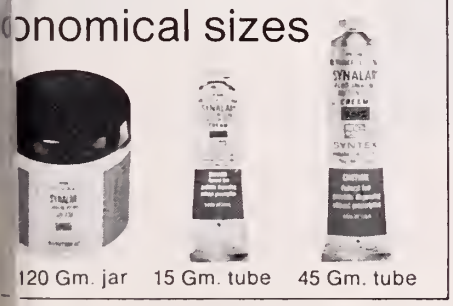

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Book Reviews

SPONTANEOUS REGRESSION OF CANCER—By Tilden C. Everson, M. D., Ph. D., and Warren H. Cole, M. D. W. B. Saunders Company; Philadelphia, London. 1966. Pp. 560. Illustrated. Price: $20.

The text elaborates upon many cases of neoplastic diseases from different sites and their prolonged survival rates. The term "spontaneous regression" is perhaps somewhat misleading in that most of the cases do not represent true spontaneous regression but solely prolonged courses of the disease.

The material within the book is subject to considerable analytical questioning and the criteria for spontaneous regression would not stand in the concepts held by many investigators. The authors, however, in their initial pages outline rather emphatically the criteria used by them to evaluate the cases. These criteria are followed in some of the cases.

The authors' contributions are to acquaint the average practitioner with the value of recognizing variable courses in neoplastic processes. Many tumors are of such variable duration that one has to be cautioned relative to conclusion as to potential survival rate in any individual case. Their review of the many long time survivals points this out and should be a warning in evaluating neoplastic diseases.

The photomicrographs demonstrate various neoplastic lesions. Some of the x-ray evidence, however, is slightly dubious and the reproductions are somewhat faulty. The conclusions based on purely clinical data are always subject to question. The recognition that even capable pathologists may at times have evaluated the microscopic erroneously has to be considered. However, many of the photomicrographs and I am certain the histologic sections are unquestionable.

The style of writing is good. The italicized emphasis is perhaps slightly misleading in some cases but demonstrative of the points the authors desire to make. The book is recommended for those who would desire analysis of cases to demonstrate variability in clinical course of neoplastic diseases.—L. Walter Fix, M. D.

EMERGENCY CARE—By Robert H. Kennedy, M. D. F. A. C. S.; W. B. Saunders Co. Philadelphia, London. 1966. Pp. 128. Illustrated. Price: $2.00.

This publication is a very excellent manual which is designed to be used in training courses for law enforcement officers, fire fighters, ambulance personnel, rescue squads and nurses where a need is seen for extending training past the advanced first aid course of the American Red Cross.

The material used in the American Red Cross First Aid textbook is omitted since this manual is used only in the training of those persons who have completed the American Red Cross Advanced First Aid Course. This is an excellent manual and although the purchaser may not use this in a training program, it is a valuable asset to all persons rendering emergency medical care and should be readily available for reference—George R. Callender, Jr., M. D.

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68 Physicians Licensed To Practice At Three Meetings of MLB

The Medical Licensing Board of West Virginia licensed 21 physicians, nine by direct examination and 12 by reciprocity, at a meeting held at The Capitol in Charleston, January 10-12, 1966. The following physicians were licensed by direct examination:

Bowie, Walter Scott, III, Westover
Dickenson, Donald Cobb, Westover
Gage, Everett Lyle, Jr., Jackson Heights, New York
Lobo, Jaldir, Huntington
Morrison, William Amos, Morgantown
Rohani, Meredith, Beckley
Siedleckie, Edward, Columbia, South Carolina
Voros, Istvan Janos, Spencer
Wang, Moses, Weston

By reciprocity:

Babin, Joseph Gordon, Fairmont
Bowling, Joseph Raphael, Huntington
Cox, Jack Edward, Fairmont
Gazzaniga, Frank Charles, Welch
Kopelman, Jerry Joshua, Beckley
Mahan, John Herman, St. Clairsville, Ohio
Medford, Frank Eldridge, Charleston
Miller, Charles Dudley, Williamson
Plybon, Benjamin Lee, Morgantown
Stackhouse, Keith Logan, Morgantown
Suess, John Frederick, Clarksburg
Wilbur, Cornelia Burwell, Weston

The Medical Licensing Board of West Virginia licensed eight physicians by reciprocity at a meeting at The

Radiology:
KARL J. MYERS, M. D.

Pathology:
S. D. WU, M. D.

Surgery:
HU C. MYERS, M. D.
A. KYLE BUSH, M. D.

Gynecology and Obstetrics:
RAYMOND W. CRONLUND, M. D.

Internal Medicine:
JOHN E. LENOX, M. D.
ERNEST G. GUY, M. D.

Anesthesiology:
G. E. HARTLE, M. D.

Dentistry:
GLENN B. POLING, D. D. S.

Brooddus Hospital Resident Staff:
LUIS GUTIERREZ, M. D.
JOSIAH THOMPSON, M. D.
HONORATO P. OLAY, M. D.
AMADO G. CHANCO, M. D.

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Barkins, Manuel, Scarsdale, New York
Bowman, Harry Thomas, Jr., Wheeling
Lancaster, Joseph Roy, Bridgeport
O'Connor, Robert Emmett, Watertown, Massachusetts
Ryan, Robert James, Trenton, New Jersey
Sherrill, Gene Donald, Charleston
Trapp, Donald Charles, Wheeling

The Medical Licensing Board of West Virginia licensed 39 physicians, 26 by direct examination and 13 by reciprocity, at a meeting held at The Capitol in Charleston, July 11-13, 1966. By direct examination:

Ahmed, Mohammed Jamil, Beckley
Atkinson, Billie Martin, Spencer
Baisden, Charles Robert, Morgantown
Bautista, Ariston Rodriguez, Montgomery
Beynon, Thomas Jesse, Weirton
Brown, Raymond Lee, Jr., Ft. Sam Houston, Texas
Campa, Jose Castillo, Beckley
Curnutte, Larry Douglas, Charleston
Edman, Clare Daniel, Charleston
Gaziano, Dominic Joseph, Morgantown
Gregg, Paul Thomas, Sistersville
Hess, David Rae, Glasgow
Holman, John Edward, Wheeling
Mearns, Thomas Jefferson, Summersville
Osborne, John Edward, Charleston
Peede, Robert Louis, Brandon, Mississippi
Plevin, Sanford Norman, Indianapolis, Indiana
Ralsten, John Neville, Durham, North Carolina
Ratcliff, Gilbert Alonzo, Jr., Huntington
Ritz, Thomas L., Wheeling
Rizzo, John Anthony, Charleston
Shamblin, Jerry Douglas, Keyser
Stemple, Larry Jack, Charleston
Tallman, Terry Tyrone, Fairmont
Toothman, Clare Jane, Vienna
Weier, Thomas Edward, St. Paul, Minnesota

By reciprocity:

Applebaum, David Ira, Morgantown
Bonney, Walter Allen, Jr., Morgantown
Daniels, Willard Floyd, Jr., Huntington
Edelstein, Joseph Melvin, Weirton
Franklin, Norman, Wheeling
Gutmann, Ludwig, Morgantown
Hall, Trevelyn Fielding, II, Morgantown
McBride, Robert Edmund, South Bend, Indiana
Nealy, Wrendell Re, Logan
Pickett, George Eastman, Ann Arbor, Michigan
Pavilack, Paul, Hollywood, Florida
Wymer, Merrill Fayne, Jr., Wheeling
Wright, Lawrence Alan, Jr., Pittsburgh

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OFFICERS OF COMPONENT SOCIETIES

Society	President		Secretary		Meetings
Barbour-Randolph-Tucker	Homer D. Martin	Dailey	A. Kyle Bush	Philippi	3rd Thurs.
Boone	W. V. Wilkerson	Whitesville	David E. Wallace	Madison	2nd Wed.
Brooke	W. T. Booher, Jr.	Wellsburg	W. T. Booher, Sr.	Wellsburg	
Cabell	Joseph M. Farrell	Huntington	Harold N. Kagan	Huntington	2nd Thurs.
Central West Virginia	Charles T. Lively	Weston	R. L. Chamberlain	Buckhannon	As Scheduled
Eastern Panhandle	C. Vincent Townsend	Martinsburg	Frank J. Gavlas	Martinsburg	2nd Wed.
Fayette	Thomas Kerr Laird	Montgomery	William L. Claiborne	Montgomery	1st Wed.
Greenbrier Valley	Stuart T. Bray	White Sulph. Springs	Arnold J. Brody	White Sulph. Sprgs.	2nd Wed.
Hancock	Eli J. Weller	Weirton	Dominic A. Brancazio	Weirton	2nd Tues.
Harrison	James A. Thompson	Clarksburg	E. Leon Linger	Clarksburg	1st Thurs.
Kanawha	George R. Callender, Jr.	Charleston	Ernest Q. Hull	South Charleston	2nd Tues.
Logan	Kwan Ho Lee	Logan	Mark S. Spurlock	Logan	2nd Wed.
Marion	Robert J. Sidow	Fairmont	G. Thomas Evans	Fairmont	Last Tues.
Marshall	David L. Ealy	Moundsville	David E. Yoho	Glen Dale	3rd Tues.
Mason	C. Leonard Brown	Pt. Pleasant	Dan Glassman	Pt. Pleasant	Bi-Monthly
McDowell	Charles F. McCord	Welch	John S. Cook	Welch	2nd Wed.
Mercer	Thomas B. Baer	Bluefield	John J. Mahood	Bluefield	3rd Mon.
Mingo	Alexander M. MacKay	Williamson	L. Lake Swigart	Williamson	2nd Wed.
Monongalia	Lawrence S. Miller	Morgantown	Robert Greco	Morgantown	1st Tues.
Ohio	James C. Hazlett	Wheeling	John Battaglino, Jr.	Wheeling	4th Tues.
Parkersburg Academy	Fay P. Greene, Jr.	Parkersburg	Charles H. Barnett	Parkersburg	1st Thurs.
Potomac Valley	Phillip G. Staggers	Keyser	Clinton L. Rogers	Keyser	2nd Wed.
Preston	J. V. Gainer, Jr.	Kingwood	C. Y. Moser	Kingwood	4th Thurs.
Raleigh	Richard G. Starr	Beckley	George A. Miller	Beckley	3rd Thurs.
Summers	Jack D. Woodrum	Hinton	J. W. Stokes	Hinton	3rd Mon.
Taylor	Charles A. Haislip	Grafton	Gene W. Harlow	Grafton	Last Thurs.
Wetzel	Lemoyne Coffield	New Martinsville	Charles P. Watson	New Martinsville	Monthly
Wyoming	Aarom Boonsue	Mullens	(Vacancy)		Quarterly

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County Societies

CENTRAL WEST VIRGINIA

Dr. Richard E. Flood of Weirton, President of the West Virginia State Medical Association, was guest speaker at the fall meeting of the Central West Virginia Medical Society, which was held at West Virginia Wesleyan College in Buckhannon on October 5.

Doctor Flood described some of the activities planned for the observance of the State Medical Association's Centennial next year and brought members up to date on third party government medical programs.

Dr. George T. Hoylman of Gassaway was elected President of the Society, succeeding Dr. Charles T. Lively of Weston. Dr. R. L. Chamberlain of Buckhannon was re-elected Secretary-Treasurer, and the new Vice President is Dr. Louis W. Groves, Jr., of Richwood.

The Society elected Dr. Robert O. Pletcher of Weston, a member of the staff of Weston State Hospital, to membership. Doctor Pletcher had been a member before leaving the state a few years ago.

* * * *

MARION

The Marion County Medical Society honored its senior members and a group of medical students at a dinner which was held at the Fairmont Field Club on September 16.

Senior members present included Drs. Guy R. Post, Ray Tuckwiller, Ford B. Rogers, Joseph P. Maxwell, Henry L. Criss and L. Rush Lambert.

Several widows of members also were present.

* * * *

McDOWELL

The Rev. Jeff Monroe was guest speaker at the regular monthly meeting of the McDowell County Medical Society which was held in Welch on October 12.

Mr. Monroe discussed the mental health program and the Council of the Southern Mountains.—John S. Cook, M. D., Secretary.

* * * *

MERCER

Dr. Robert W. Neilson of Bluefield was the principal speaker at the regular monthly meeting of the Mercer County Medical Society, which was held at the West Virginian Hotel in Bluefield on September 19.

Doctor Neilson, who returned recently from a two-month tour of duty with "Project Vietnam," de scribed his experiences in Danang and illustrated his talk with slides. He commented on the poor environmental health of the natives and stated that a great amount of good will is being generated by U. S. medical teams in South Vietnam.

Dr. Frederick T. Edmunds was elected to membership as a transfer from the Kanawha Medical Society. —John J. Mahood, M. D., Secretary.

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NOVEMBER
1966

Vol. 62 No. 11

The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Association

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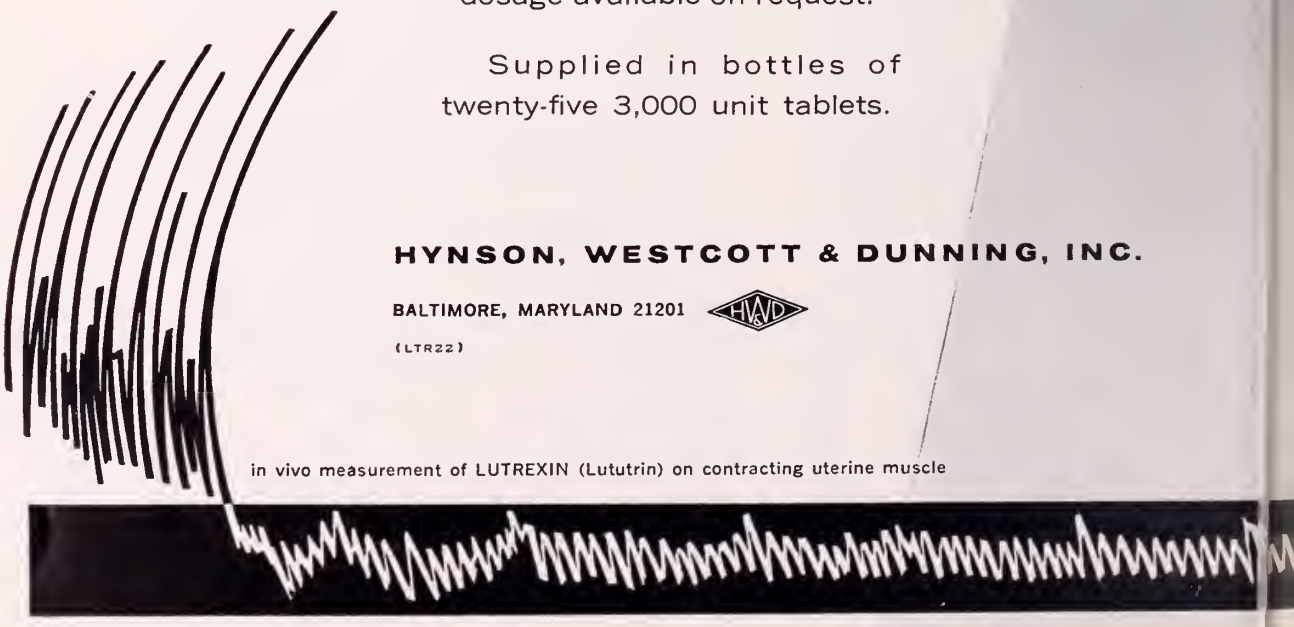

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Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss, which may cause digitalis intoxication, responds to potassium-rich foods, potassium chloride or, if necessary, stopping therapy. Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy two weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution with patients with peptic ulcers or renal insufficiency (if severe, Salutensin is contraindicated).
Side Effects: Hydroflumethiazide: Purpura plus or minus thrombocytopenia, hyperuricemia, leukopenia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)
Usual Dose: 1 tablet *b.i.d.*

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WVU Medical Center
—News—

SEVERAL additional appointments to the faculty of the School of Medicine have been announced by Dr. Harry B. Heflin, Acting President of WVU.

The most recent appointments include:

Dr. Hawey A. Wells, Jr., was named Assistant Professor of Pathology, effective September 1. A native of Mercer County, Doctor Wells received his M. D. degree in 1960 from the Medical College of Virginia, and most recently has been serving with the U. S. Public Health Service in Beckley.

Dr. Robert C. Hamilton was appointed Assistant Professor of Anesthesiology. Doctor Hamilton was born in Northern Ireland and received his medical degree from Queen's University in Belfast in 1957.

Dr. George P. Savvas has joined the Department of Anatomy as an Instructor. Doctor Savvas is a native of Athens, Greece, and earned his medical degree three years ago at the University of Athens, where he taught human anatomy until 1965.

Dr. John J. Smith, a New Jersey native, has become Assistant Professor of Psychiatry. He received his M. D. degree in 1959 from George Washington University, and for the past three years, he has been clinical director at Athens State Hospital in Athens, Ohio.

Dr. George W. Sciple has been appointed Associate Professor of Preventive Medicine. A native of Atlanta, Georgia, Doctor Sciple received his M. D. degree in 1957 from Emory University. He was an instructor at Emory and later at the Baylor and University of Colorado medical schools.

Family Planning Clinic

A Family Planning Clinic, aimed mainly at helping indigent persons cope with problems of birth control, opened on September 14 as part of the Out-Patient Department of University Hospital.

The clinic is for patients who have been referred by family physicians. It begins at 1 P.M. each Wednesday.

Dr. Walter H. Bonney, Jr., who joined the School of Medicine in July, is in charge of the program. He occupies the Margaret Higgins Sanger Chair of Family Planning and Reproductive Physiology under a $500,000 gift to WVU by Mrs. Cordelia S. May of Ligonier, Pennsylvania.

Genetics Counseling

Genetics counseling is now available at the Medical Center.

• **Compiled from material furnished by Arthur V. Ciervo, Director, Medical Center News and Information Services, Morgantown, West Virginia.**

Dr. Richard C. Juberg, Assistant Professor of Pediatrics, is director of the clinic in human genetics.

The services of the clinic are available to couples who have had abnormal children; people who wonder whether there is a genetic reason for their barrenness; physicians and others.

Coronary Drug Project

Fifteen persons participating in the first phase of the extensive Coronary Drug Project met on September 8 with several members of the staff of the Medical Center.

Eventually, the project will involve about 200 persons at the Medical Center and 8,000 at other institutions. Dr. David Z. Morgan is principal investigator for the five-year project.

Volunteers for the study must be males between the ages of 30 and 65 who have suffered heart attacks. Persons may volunteer for the project with the approval of the family physician by contacting Doctor Morgan.

Guest Lecturers

Dr. W. Horsley Gantt, an international authority on the nervous system, will lecture twice at the Medical Center in November.

Doctor Gantt, whose home is in Baltimore, is a neurophysiologist and psychiatrist. He is chief scientist of the psychophysiology laboratory, U. S. Veterans Administration Hospital, Perry Point, Maryland.

On November 3, Doctor Gantt will conduct a seminar for faculty, staff and students of the School of Medicine. The next day at 4 P.M., he will lecture on "Emotions and the Heart" in the Medical Center Auditorium. The public is invited.

A graduate of the University of Virginia School of Medicine, Doctor Gantt received the Lasker Award in 1946 for his research in nervous diseases, and the American Heart Association Award in 1955 for his research on causes of high blood pressure. He is the author of more than 300 publications in scientific journals and has written or contributed to about 20 books.

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David M. Wayne, M. D.

Beckley Mental Health Center
109 E. Main Street, Beckley, W. Va.
W. E. Wilkinson, M. D.

Charleston Mental Health Center
1206 Quarrier St., Charleston, W. Va.
E. E. Gimenez, M. D.

Mental Health Clinic
Professional Building, Wise, Va.
Pierce D. Nelson, M. D.

The Month in Washington

• From the Washington Office of the American Medical Association.

A new minimum wage law is expected to cause hospital and nursing home costs to rise. It brings about 1.5 million workers in hospitals and nursing homes under the federal minimum wage program for the first time. The minimum wage for them is set at $1.00 an hour for next year, $1.15 an hour in 1968, $1.30 an hour in 1969, $1.45 an hour in 1970 and $1.60 an hour thereafter.

The new law also increases the minimum wage for about 30 million workers presently covered to $1.40 an hour on February 1, 1967, and to $1.60 an hour on February 1, 1968.

On a related front, Senate Democratic Leader Mike Mansfield said he believed the Health, Education and Welfare Department was going too fast in enforcing racial desegregation of Southern hospitals and schools. He told newsmen he supported the Senate's denial of $500,000 sought by HEW to pay civil rights investigators. He said the Senate wants to see desegregation handled carefully rather than impulsively.

Hospital and school authorities "will be on trial," Senator Mansfield said, and if they abuse the suggested latitude, Congress can move quickly to correct the situation.

"We have to take things slowly . . ." he said. "This is an area of great delicacy. The thing to do is to do it right and not precipitously."

The Senate approved legislation that would give nursing homes more liberal payment for Medicare patients. The bill amends the definition of reasonable costs to include return on the fair market value of the facilities. The existing federal reimbursement formula is two per cent above operating costs. Nursing home operators contend this is too low.

HEW Undersecretary Wilbur Cohen said the government will watch carefully to determine whether patients are admitted unnecessarily to hospitals next year in order to qualify them for Medicare's nursing home benefits. The law requires that nursing home benefits be made available only to Medicare beneficiaries who have had a hospital stay of three days or more and only when the nursing home care is considered an extension of the hospital treatment. However, several bills have been introduced in Congress to eliminate the hospital stay requirement.

Air Pollution Bill

The American Medical Association supported a bill that would extend the air pollution control program and authorize increased appropriations for it.

In a letter to a Senate subcommittee, Dr. F. J. L. Blasingame, Executive Vice President of the AMA, noted that the Association's House of Delegates in June, 1965, had adopted a statement recognizing the health hazards resulting from air pollution and recommending that feasible reduction of all forms of air pollution should be sought by all responsible parties. The pending bill (S. 3112) "can further this end," he said.

"We believe the effect of this amendment will be beneficial," he said. "The grant mechanism should bolster local and regional operations, encouraging a greater degree of local initiative, particularly in interstate and intermunicipal areas. In addition, the bill would eliminate a serious inequity in the present law. Certain metropolitan regions are penalized in that they cannot obtain assistance for maintaining their currently large and expensive programs, while a metropolitan region without a program could receive up to two-thirds of the cost of creating a new program Under the proposed legislation this inequity would be eliminated."

Narcotics Addiction Bill

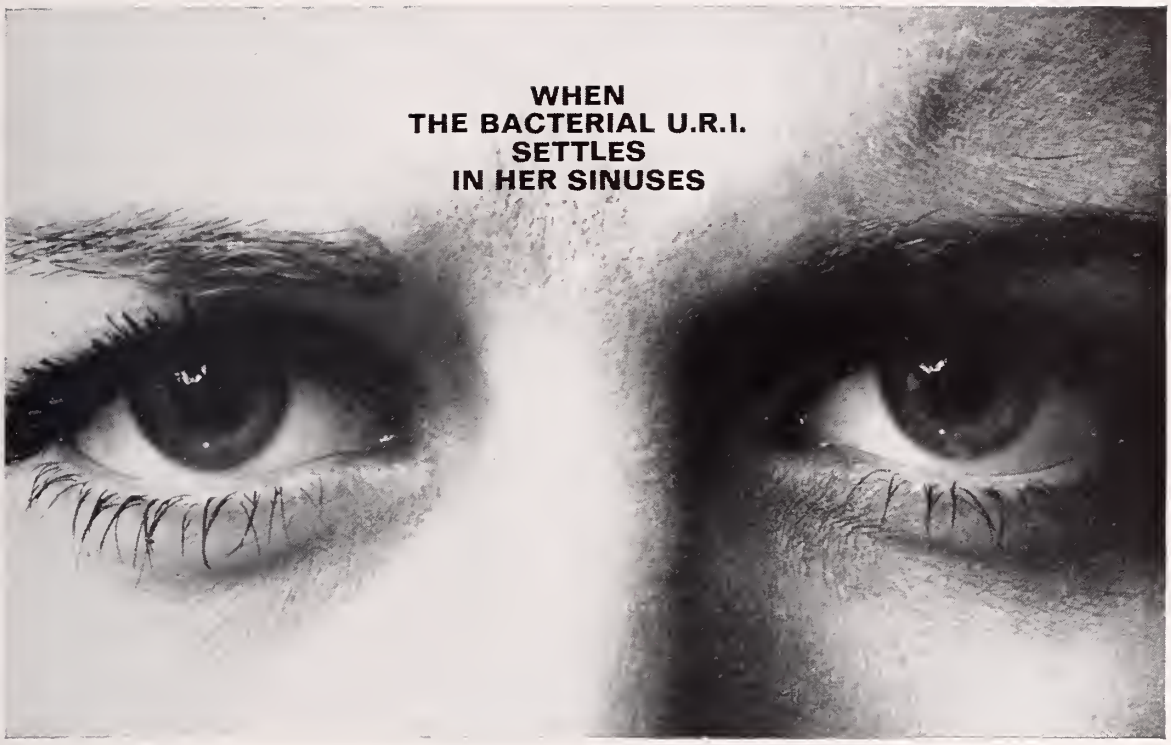
The Senate cleared the path for a new approach to narcotics addiction which would substitute hospital treatment for long-term prison sentences.

The Senate approved the legislation by voice vote without dissent and sent it to a Senate-House conference committee for adjustment of differences with a House version.

The key to the bill is civil commitment for the addict involved in a non-violent crime. It would provide voluntary pre-trial commitment in lieu of prosecution and compulsory post-conviction commitment in lieu of punishment. In addition, the bill would provide voluntary and compulsory commitment of certain addicts not charged with any crime. The addicts would be committed to the Surgeon General for confinement and treatment in a hospital or institution. Treatment would continue within the community after the addict is discharged.

The legislation also would establish federal post-hospitalization treatment centers and also give courts more flexibility in dealing with youthful drug offenders.

Sen. John L. McClellan, who brought the bill to the Senate floor, said it "affords an opportunity for narcotics addicts who wish to extricate themselves from a hopeless life of addiction and crime to have themselves committed for treatment."



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Precautions—Some individuals may experience drowsiness, anorexia, and slight gastric distress. If excessive drowsiness occurs, it may be necessary to increase the interval between doses. Persons on full dosage should not operate any vehicle. Use may result in overgrowth of nonsusceptible organisms. If infections appear during therapy, appropriate measures should be taken. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Infections caused by beta-hemolytic streptococci should be treated for at least 10 full days to help prevent rheumatic fever or acute glomerulonephritis. Use of tetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect has been observed in usual short treatment courses.

Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals.

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Obituaries

GIBSON CARR SMITH, M. D.

Dr. Gibson C. Smith, who was engaged in general practice in Weirton in the 1940s and 1950s, died at his home in San Diego, California, on September 22. He was 49.

A native of Boston, Massachusetts, Doctor Smith received an A. B. degree from the University of Tennessee in 1940 and earned his M. D. degree at the University of Wisconsin four years later. He practiced in Weirton for seven years prior to moving to North Carolina in 1955 and eventually to California.

He was a former member of the West Virginia State Medical Association.

Survivors include the widow, Mrs. Ann Smith; two daughters, Cecilia Ann and Dorothy Jean; two brothers; and two sisters.

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Medical Aspects of Sports Meeting in Las Vegas

The 8th National Conference on the Medical Aspects of Sports, sponsored by the American Medical Association, will be held in Las Vegas, Nevada, on Sunday, November 27, in connection with the AMA Clinical Convention.

The all-day session will be at Caesar's Palace.

Dr. Richard W. Corbitt of Parkersburg, Vice President of the West Virginia State Medical Association and Chairman of the Association's Committee on the Medical Aspects of Sports, will be among the speakers.

Other speakers will include:

Dr. Merritt Stiles, Second Vice President of the U. S. Olympic Committee; Dr. Donald O'Donoghue, President of the American Academy of Orthopedic Surgeons; and Dr. Robert S. Rocke, Medical Examiner for the California State Athletic Commission.

The Conference is open to key nonmedical personnel as well as physicians and will cover a wide range of subjects of interest to those serving school and college athletic programs. Included will be forums and discussion sections relating to criteria for immediate management of knee injuries, resources for grass roots supervision of sports, medical preparations for international competitions, and the relationship of athletic fitness to physical fitness.

Additional information may be obtained by writing to the Secretary, Committee on the Medical Aspects of Sports, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

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President Elect: Mrs. Rupert W. Powell, Fairmont
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Corresponding Secretary: Mrs. William T. Lawson, Fairmont
Parliamentarian: Mrs. D. E. Greeneltch, Wheeling

23rd ANNUAL CONFERENCE IN CHICAGO

The 23rd Annual Conference of State Presidents, Presidents Elect, National Officers and Committee Chairmen of the Woman's Auxiliary to the American Medical Association was held at The Drake Hotel in Chicago, October 2-4.

Representing West Virginia were Mrs. Hu C. Myers of Philippi, President of the Woman's Auxiliary to the West Virginia State Medical Association and Mrs. Rupert W. Powell of Fairmont, President Elect.

Mrs. Asher Yaguda, President of the Woman's Auxiliary to the American Medical Association, called the meeting to order, and Mrs. Karl F. Ritter, President Elect, presided.

Speakers included Dr. Ellen Winston, U. S. Commissioner of Welfare; Dr. Charles L. Hudson, President of the American Medical Association; Howard Hassard, Executive Director of the California Medical Association; Dr. Henry I. Fineberg, Executive Vice President of the Medical Society of the State of New York; and His Excellency Vu Van Thai, Vietnam's Ambassador to the United States.

Dr. Norman Hoover of the Mayo Clinic; Dr. Ernest B. Howard, Assistant Executive Vice President of the AMA; Mrs. Yaguda; Mrs. Samuel Gendel, Auxiliary Chairman of International Health Activities; Mrs. Herbert J. Ulrich, Chairman of Health Careers; and Mrs. Burton E. Kinter, Chairman of Philanthropy.

The Auxiliary's National Eastern Regional Workshop was held in New York City, October 10-11.

Members of the Woman's Auxiliary to the West Virginia State Medical Association who received invitations to attend the workshop were:

Mrs. Hu C. Myers, President; Mrs. Rupert W. Powell, President Elect; Mrs. Bruce Martin, Chairman of AMA-ERF; Mrs. James H. Walker, Chairman of Community Service; Mrs. Charles H. Hiles, Chairman of Health Careers; Mrs. Charles W. Merritt, Chairman of Legislation, and Mrs. John W. Hash, Chairman of Mental Health—Mrs. Rupert W. Powell, President Elect.

HANCOCK

The Woman's Auxiliary to the Hancock County Medical Society opened its 1966-67 program with a luncheon meeting at Williams Country Club in Weirton in September.

Members volunteered their services to be hostesses at various hospital booths during Community Health Week in October at Weirton General Hospital.

Mrs. Myer Bogarad reported that 11 children were remembered on their birthdays since May 1 at the Hancock County Children's Home.

Twelve members attended the meeting.

* * * *

HARRISON

Mrs. Hu C. Myers of Philippi was guest of honor at the annual tea of the Woman's Auxiliary to the Harrison County Medical Society which was held at the home of Mrs. Albin A. Galuszka in Clarksburg on September 22.

In the receiving line were Mrs. Myers, President of the Woman's Auxiliary to the West Virginia State Medical Association; Mrs. Galuszka, President of the Harrison County Auxiliary; Mrs. Rupert W. Powell of Fairmont, State President Elect; Mrs. Robert Bess, Jr., of Westernport, Maryland, a Vice President of the State organization; and Mrs. Hugh M. Brown, President Elect of the Harrison County group.

More than 35 members and guests attended.

* * * *

KANAWHA

New members of the Woman's Auxiliary to the Kanawha Medical Society were welcomed at a coffee at the home of Dr. and Mrs. Joel Allen in Charleston.

New members honored were Mesdames Philip M. Rubin, Bobby Caldwell, Robert L. Leadbetter, Edwin C. Neville, Morris H. O'Dell and Frank E. Medford.

The Auxiliary received letters of appreciation from two students it is sponsoring at the Morris Harvey College School of Nursing; and voted to continue several programs it has been sponsoring in recent years.

The Woman's Auxiliary to the Kanawha Medical Society held its October meeting at the home of Dr. and Mrs. Thomas G. Reed in Charleston.

Several members of the Auxiliary discussed the group's various projects. Mrs. James H. Walker explained the community service program and Mrs. James T. Spencer reported that 7,000 children in Kanawha County were tested last year in the Auxiliary's hearing testing program.

Mrs. Grover B. Swoyer explained the health careers program; and Mrs. Clarence E. Stennett spoke on AMA-ERF. Mrs. N. H. Newhouse outlined the need for more clothing for the Clothing Chest.—Mrs. H. A. Jackson, Publicity Chairman.

LOGAN

The regular monthly meeting of the Woman's Auxiliary to the Logan County Medical Society was held at the home of Dr. and Mrs. Ray M. Kessel on September 28.

Members of the Auxiliary discussed programs for the coming year. Ten members attended the meeting.

* * * *

McDOWELL

Mrs. Hu C. Myers of Philippi, President of the Woman's Auxiliary to the West Virginia State Medical Association, was guest speaker at the regular monthly meeting of the Auxiliary to the McDowell County Medical Society, which was held at the home of Dr. and Mrs. John S. Cook in Welch on September 14.

Mrs. Myers, accompanied by Mrs. John J. Mahood of Bluefield, State Program Chairman, complimented the McDowell County Auxiliary for surpassing the quota in raising funds for AMA-ERF.

Mrs. C. F. McCord and Mrs. Ray E. Burger were co-hostesses for the luncheon meeting, which was attended by 13 members and four guests.—Mrs. C. F. McCord, Secretary.

* * * *

MARION

The Woman's Auxiliary to the Marion County Medical Society held its annual membership coffee at the home of Dr. and Mrs. John D. Lindsay in Fairmont on September 27.

Mrs. Rupert W. Powell of Fairmont, President Elect of the Woman's Auxiliary to the West Virginia State Medical Association, gave a report on the state convention at The Greenbrier in August.

Fall flowers were used throughout the Lindsay home for the party. Mrs. Lindsay was Chairman for the coffee, assisted by Mrs. John W. Kramer.

* * * *

RALEIGH

Mrs. Hu C. Myers of Philippi, President of the Woman's Auxiliary to the West Virginia State Medical Association, was guest speaker at the regular monthly meeting of the Woman's Auxiliary to the Raleigh County Medical Society, which was held in Beckley in September.

Mrs. Myers appealed to the members to continue their interest in AMA-ERF. She also announced that an exhibit of old medical instruments is being planned as part of the celebration of the State Medical Association's 100th anniversary next year.

Hospital Staff Promotions

Eugene L. Staples, Director of West Virginia University Hospital, announced two promotions on the administrative staff.

Leroy Miller was named Associate Director, succeeding Alan M. Gilbert, who accepted a position in Florida. Charles F. Pinkerman was advanced from Administrative Assistant to Assistant Director, the position formerly held by Miller.

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hy is one man's gastric ulcer nother man's duodenal?

Geographic variation in the *incidence* of peptic ulcer is a familiar fact. But the proclivity of certain *kinds* of ulcer for certain geographic areas is a recently recognized phenomenon.[1,2]

For example, in one particular Norwegian fishing village there is a tendency for patients to develop a gastric ulcer; anywhere else in Norway, ulcers are usually duodenal. Peruvians high in the Andes have more gastric ulcers than their compatriots in the lowlands. Why? Nobody knows.

Social variations, too. Even in the same raphic areas there are interesting variations. An Englishman's ulcer depends is social standing—professional men suffer with duodenal ulcers, while kingmen have more of the gastric variety. In southern India the pattern is rsed. Here, duodenal ulcers are common among laborers and agricultural kers and rare among the upper classes.

nvestigators are exploring every possible theoretical avenue in their search he cause of peptic ulcer. Of all the factors implicated in ulcerogenesis, one that is generally acknowledged to be of primary importance is hyper-tion of gastric acid.[3-8] Or, as one author states it: "The medical management eptic ulcer pharmacologically is, in the final analysis, concerned largely the effective inhibition of peptic activity."[3]

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Contraindications: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.
Precautions: Administer with caution in the presence of incipient glaucoma.
Adverse Reactions: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.
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References: **1.** Jones, F. A., and Gummer, J. W. P.: Clinical gastroenterology, Springfield, Ill., Charles C Thomas, 1960, pp. 322-3. **2.** Bockus, H. L.: Gastroenterology, 2nd ed., vol. I, Philadelphia, Saunders, 1963, p. 468. **3.** Sun, D. C. H.: Ann NY Acad Sci 99:153 (Feb. 28) 1962. **4.** Moore, V. A.: Postgrad Med 38:216 (Sept.) 1965. **5.** Dragstedt, L. R., Woodward, E. R., Storer, E. H., Oberhelman, H. A., Jr., and Smith, C. A.: Ann Surg 132:626 (Oct.) 1950. **6.** Posey, E. L., Jr., Smith, P., Turner, C., and Aldridge, J.: Amer J Dig Dis 10:399 (May) 1965. **7.** Lamphier, T. A., Siegel, L., and Goldberg, R. I.: Amer J Gastroent 37:551 (May) 1962. **8.** Kasich, A. M., and Fein, H. D.: Ibid 39:61 (Jan.) 1963. **9.** Epstein, J. H.: Ibid 37:295 (Mar.) 1962. **10.** Moeller, H. C.: Ann NY Acad Sci 99:158 (Feb. 28) 1962. **11.** Slanger, A.: J New Drugs 2:215 (Jul.-Aug.) 1962. **12.** Barman, M. L., and Larson, R. K.: Amer J Med Sci 246:325 (Sept.) 1963. **13.** Shutkin, M. W.: Amer J Gastroent 38:682 (Dec.) 1962. **14.** Fleshler, B.: J New Drugs 2:211 (Jul.-Aug.) 1962.

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Book Reviews

MODERN HOME REMEDIES AND HOW TO USE THEM—By Morris Fishbein, M. D.; Doubleday and Company, Inc. 1966. Pp. 128. Price: $3.95.

This small book of 124 pages, by Dr. Morris Fishbein, is of some interest to non-medical readers and many doctors may find a reason why and to what extent patients prescribe for and treat themselves.

The preface contains some good advice to people who like "over the counter" remedies and the first chapter gives some simple rules from a pamphlet by the Food and Drug Administration, which should be helpful to the patient "on his own."

Sixteen chapters are devoted to various ailments and conditions such as pain, cold, constipation, care of the feet et cetera.

There is no advice concerning the evaluation of television drug commercials and this is what the self-medication patient needs most at this time.

At $3.95, the book is financially overrated.

* * * *

ATLAS OF HERNIA REPAIR—By Carl H. Calman, M. D., F. A. C. S., formerly Assistant in Clinical Surgery, Washington University School of Medicine, St. Louis, Missouri. The C. V. Mosby Company, St. Louis. 1966. Pp. 159. Illustrated. Price: $16.75.

A very good atlas with an adequate presentation of the anatomy involved, classification of hernias and complications. The description of the various techniques for herniorrhaphy are for the most part adequately covered. The diagrams are very easy to follow. The hernias of the diaphragm, the lumbar triangle and the internal peritoneal cavity are very concisely outlined. The main shortcoming of this atlas is the fact that many time-honored techniques which have been proven to give good results have been omitted.

The construction of this book is beautiful, mainly because of the high grade paper used thus necessitating the rather high cost.—Kenneth G. MacDonald, M. D.

* * * *

ENCYCLOPEDIA FOR MEDICAL ASSISTANTS.—By Louis Brachman, M. D. Pp. 441. Cathedral Square Publishing Company, Cathedral Square, Milwaukee, Wisconsin 53202.

This 441-page book is a treasure of medical information for the medical assistant, whether the assistant be a nurse, secretary or bookkeeper. There is an abundance of information concerning all these subjects within the book.

The section on financial records may be particularly helpful to the busy practitioner. There is a 35-page dictionary of medical terms which covers most of the medical words used in office records or dictation and will be helpful to the secretary and should save explanatory time on the part of the physician. Many offices will find this a very helpful guide to multiple activities in the medical office.

EMPHYSEMA IN INDUSTRY (Medical Series Bulletin No. 10)—Robert T. P. deTreville, M. D., Managing Director, Industrial Hygiene Foundation, Pittsburgh. 1966. Industrial Hygiene Foundation, Mellon Institute, 4400 Fifth Avenue, Pittsburgh, Pennsylvania 15213. Price $2.50 per copy for members and $5.00 per copy for non-members.

This bulletin will be interesting to all physicians who have emphysematous patients among their clientele. It covers the anatomy and histology of the disease. The clinical aspects and medico-legal angles are discussed at some length. Any physician should have a better understanding of chronic bronchitis and emphysema after reading this interesting symposium. Most of the story is in terms that the lay industrialist can understand.

Minneapolis Doctor Receives Award

Dr. Richard M. Magraw of Minneapolis has received the 1966 Norman A. Welch Memorial Award for his book *Ferment in Medicine.*

The presentation of the gold medal was made at the Annual Program Conference of the National Association of Blue Shield Plans in Chicago on October 10. The Blue Shield organization also is contributing $1,000 in Doctor Magraw's name to the American Medical Association's Education and Research Fund.

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Direct Billing of Patients Urged Under Medicare Program

The right of the physician to bill the patient directly for services rendered is one of the most important features of Part B, Title 18, Public Law 89-97. The American Medical Association House of Delegates has repeatedly urged physicians to utilize this option rather than to receive payment from intermediary agents. Early information on Medicare billing, however, indicates that an appreciable percentage of physicians is being reimbursed by the intermediary agent. This percentage is likely to change since claims resulting from direct billing are expected to take longer to reach the intermediaries for payment.

In the long run, the willingness to deal directly with the fiscal intermediaries of government will prove to be a serious blunder. It is one matter to accept payments based on determinations of "reasonable" fees by Blue Shield plans and health insurance companies that operate as free agents, usually with close medical society liaison. It is another to accept such direct payments from carriers that must operate as fiscal agents of the federal government.

The interposition between government and the physician or carrier "intermediaries" does not alter the basic fact that the federal government is responsible under Part B, Title 18, PL 89-97, for financing most of the benefits. Under the law the responsible governmental operating agency must assume authority that it cannot delegate to any private group. Inevitably, governmental medical care programs encounter cost control problems. Fee schedules, mandatory generic drug prescribing, elimination of "unnecessary" diagnostic tests and therapeutic agents, and other actions that impinge on the physician's professional freedom, are common developments, usually promoted under the guise of quality control.

Direct billing of the patient makes these developments less likely and preserves a physician-patient relationship relatively free from government control. It carries the risk of non-payment of some bills, but this loss is more than offset by the gain in professional control of the rendition of medical care.—*The AMA News.*

The Team That Does So Much

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Side Effects: Hydroflumethiazide: Purpura plus or minus thrombocytopenia, hyperuricemia, leukopenia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)
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WVU Medical Center
—News—

• Compiled from material furnished by Arthur V. Ciervo, Director, Medical Center News and Information Services, Morgantown, West Virginia.

SEVENTEEN more students in the School of Medicine have been awarded scholarships for the current academic year. The awards were announced by Dr. Clark K. Sleeth, Dean of the School of Medicine.

Presented Carr Scholarships, worth $800 each, were:

Sophomore students R. E. Henebaugh of Run Road, Pennsylvania; R. C. Nerhood of Charles Town, and J. E. Richardson of South Charleston; juniors J. V. Merrifield of Charleston and R. R. Six of St. Albans; and seniors J. C. Arnett, Jr., of Rowlesburg; and J. R. Morgan of Charleston.

The Claude Worthington Benedum Foundation awarded $460 scholarships to:

Sophomore Thomas R. Hables of Aldenville, Pennsylvania; Juniors Charles V. Porter of McMechen, Leonard G. Prutsok of Philippi, and Tommy Turner of Huntington; and seniors Lewis V. Campbell of Gallipolis, Ohio, Richard S. Kerr of Morgantown, Albert J. Kolibash of Benwood, Lewis H. McConnell of West Union, James D. Morrison of Huntington, and Robert K. Webb of Sistersville.

Each scholarship winner ranks in the upper 50 per cent of his class.

The names of other scholarship recipients were published in previous issues of *The Journal.*

Faculty Appointments

The appointment of Dr. Jacob Hildebrandt as Assistant Professor of Physiology in the School of Medicine has been announced by Dr. Harry B. Heflin, Acting President of the University.

A native of Canada, Doctor Hildebrandt received his B. A. degree in 1957 from the University of British Columbia and an M. S. degree in 1960 from the same institution. Under a National Institutes of Health Fellowship, he attended the University of Washington and earned his doctorate in 1966.

Prior to his appointment at WVU, Doctor Hilldebrandt was Instructor in Physiology at the University of Washington.

These other appointments to the School of Medicine faculty were announced recently by Doctor Heflin:

Dr. Naomi Goldfarb Kaplan of Hohokus, New Jersey, has joined the School of Medicine as an Instructor in Pathology.

Doctor Kaplan is a graduate of Skidmore College and received her M.D. degree in 1962 from New York University School of Medicine. For the next three years, she trained there as a resident in pathology.

Mr. Robert J. Gribben of Fairmont has been appointed Instructor in Psychiatry.

A native of Wheeling, Mr. Gribben is a graduate of Wheeling College and holds a master's degree in social work from WVU. Prior to his appointment at WVU, he was a social worker with the Children's Home Society in Charleston for two years and later with the Children's Aid Society in Philadelphia for one year.

International Cancer Conference

Dr. Alvin L. Watne, Associate Professor of Surgery in the School of Medicine, attended the 9th International Cancer Conference in Tokyo, October 22-29.

Doctor Watne presented a paper, "Host Resistance and Cancer Chemotherapy," which is based on research he conducted with Dr. Bedrettin Gorgun, now of the University of Istanbul in Turkey.

Doctor Watne's trip was sponsored by the National Science Foundation.

Visiting Lecturers

Dr. John C. Gallagher, a noted pathologist, will lecture at the Medical Center on December 12.

Doctor Gallagher will address faculty, staff and students on "Normal Gross Anatomy and Microanatomy of the Temporal Bone and Micropathology of the Temporal Bone." The lecture will begin at 4:30 P.M. in Room 2118 of the Basic Sciences Building.

Doctor Gallagher serves as Chief of Otolaryngologic Pathology at the Armed Forces Institute of Pathology in Washington.

Dr. Henrik Holt Bendixen of Harvard Medical School presented a paper entitled "The Respiratory Care Unit" on November 18 at the Medical Center. He is an Assistant Clinical Professor at Harvard.

Dr. Francis O. Schmitt, a pioneer in molecular biology, gave two lectures at the Medical Center on November 17.

The titles of his papers were "Protein Specificity in Nerve Function" and "Molecules, Memory and Learning."

Doctor Schmitt is Institute Professor and Chairman of the Neurosciences Research Program at Massachusetts Institute of Technology.

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The Month in Washington

• **From the Washington Office of the American Medical Association.**

HIGH on the list of health legislation to be considered by the new Congress convening on January 10 are proposals to amend both the Medicare and Medicaid programs. Proposed Medicare amendments would extend the program to the disabled, include podiatrists' services, add out-patient drugs to Plan B, and authorize that billing for services of hospital-based physician specialists be put back under hospitals.

Sen. Russell B. Long, (D., La.), chairman of the Senate Finance Committee which handles Medicare and Medicaid legislation, is pushing a proposal designed to get physicians to prescribe drugs by generic terms for patients under federally-aided medical programs. Such an amendment died in a conference committee in the final days of the last Congress.

Amendments to limit federal expenditures under Medicaid (Title XIX) are expected to get early consideration by the House Ways and Means Committee. The committee reached agreement on such legislation shortly before adjournment last year, but it was too late to get it through Congress.

Liberalization of Keogh Law

One of the final pieces of legislation passed by Congress in 1966 authorizes liberalization of the Keogh law under which physicians get a tax break for savings put in qualified pension plans. The full amount of the $2,500 annual maximum was made tax deductible. Only half of the amount was tax deductible under the original law.

Other health legislation approved by Congress in 1966 includes:

Group practice—authorizes federal mortgage guarantees for construction of non-profit group practice facilities.

Health services—authorizes the Office of Economic Opportunity (anti-poverty) to make grants for comprehensive health services programs, including birth control.

Public health—authorizes (1) $145 million, one-year extension of PHS programs, including $125 million for project grants for categorical programs. States and the PHS are given greater flexibility in spending the money among the various categories and including other "public health" projects; (2) extends the federal-aid vaccination program for three years; and (3) provides for family health services for migratory workers.

Air pollution—authorizes a three-year, $186 million extension of the federal anti-air pollution program and provides broader authority for air pollution control activities by localities.

Water pollution—authorizes a $3.7 billion, four-year program for cleaning the nation's waterways. It includes initiation of a massive program for combatting pollution in major water basins.

Child care—prohibits sale of toys containing hazardous substances and strengthens existing law covering household hazardous substances; does not contain a disputed provision covering children's aspirin and other drug controls in the original legislation.

Narcotics—permits addicts charged with non-violent crimes to choose hospital commitment instead of trial, if the authorities agree, or could be sentenced after trial to hospitals for rehabilitation.

Packaging—requires that over-the-counter drugs and grocery products bear labels clearly showing the contents, quantity, and manufacturer.

Mental health—amends original law to provide grants to assist in the establishment and initial operation of community mental health centers.

Research laboratory animals—provides for federal regulations covering transportation, purchase, sale, housing, care, handling and treatment of such animals.

Military medicare—amends existing law to provide for out-patient care in a physician's office and to include retired reservists and their dependents.

Allied health professions—authorizes $105 million for a three-year program to train more medical technicians, therapists and other allied health workers.

Alcoholism Program

The federal government has launched an extensive program to control and prevent alcoholism.

As initial steps, Health, Education and Welfare Director John W. Gardner established a National Center for the Prevention and Control of Alcoholism and appointed an 18-member National Advisory Committee on Alcoholism.

In announcing the program, Mr. Gardner stated its two major aims:

(1) The immediate goal of making the best treatment and rehabilitation services available to those who need them now—through both the stimulation of existing resources and the development of new manpower and facilities.

(2) The long-range goal of developing effective, practical, and acceptable methods of preventing alcoholism and excessive drinking in all their destructive forms and developing improved therapeutic techniques.

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Obituaries

JOHN JENKINS COOGLE, M. D.

Dr. John J. Coogle of Fairmont died in a hospital in that city on October 25 after an attack of hepatitis. He was 45.

A native of Rivesville, Doctor Coogle earned a B. S. degree at West Virginia University and an A. B. degree at Fairmont College before earning his M. D. degree at the Medical College of Virginia in 1950.

He interned at Ohio Valley General Hospital in Wheeling and served a four-year residency in surgery at the Veterans Administration Hospital in Richmond, Virginia. He specialized in general surgery.

During World War II, Doctor Coogle served as a navigator in a bomber group in the Pacific.

He was a member of the Marion County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the mother; the widow, Lola Dean Coogle; three children, Constance, John and Jeffery; and a brother, William L. Coogle, Jr., of Fairmont.

* * * *

JAMES G. LEECH, M. D.

Dr. James G. Leech of Hinton died in a hospital in that city on October 31. He was 82.

Doctor Leech had practiced at Quinwood before his retirement. He attended the University of Virginia, the Medical College of Virginia and the University of the South in Sewanee, Tennessee.

Doctor Leech was a Past President of the Greenbrier Valley Medical Society and was an honorary member of the West Virginia State Medical Association and the American Medical Association.

* * * *

PHILIP PREISER, M. D.

Dr. Philip Preiser, 64, died in a Charleston hospital on November 3 after suffering a heart attack.

A native of New York City, Doctor Preiser attended West Virginia University and received his M. D. degree in 1929 from the University of Chicago School of Medicine.

He was a Diplomate of the American Board of Internal Medicine and was a member of the Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow, Mrs. Ida Preiser; two daughters, Mrs. Harvey Sherman of Charleston and Mrs. Robert Lerner of Highland Park, Illinois; four sisters, Mrs. Maurice Hubberman of Detroit; Mrs. Isadore Davidson and Mrs. Kople Line of Charleston, and Mrs. Joseph Sanders of Miami, Florida; and two brothers, Benjamin and Alex S. Preiser, both of Charleston.

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County Societies

CABELL

Mr. Angus Peyton, State Commerce Commissioner, and Mr. Robert N. Campbell, West Virginia Medicare Manager for Nationwide Insurance Company, were guest speakers at the regular monthly meeting of the Cabell County Medical Society which was held at the Hotel Frederick in Huntington on September 8.

Mr. Peyton discussed the development of roads and parks in West Virginia. Mr. Campbell discussed various matters pertaining to billing under the Medicare program.

Dr. U. C. Lovejoy was elected to membership in the Society as a transfer from the Kanawha Medical Society. Drs. C. Dudley Miller and James Aaron Lilly also were admitted to the Society.

Dr. Albert C. Esposito of Huntington discussed the scholarship fund for children of deceased members of the Society.

Forty-three members and guests attended the meeting.—Harold N. Kagan, M. D., Secretary.

* * * *

HARRISON

Dr. Robert Nugent of the West Virginia University School of Medicine was guest speaker at the regular monthly meeting of the Harrison County Medical Society which was held at the Stonewall Jackson Hotel in Clarksburg on November 3.

Doctor Nugent discussed emergency problems resulting from injuries to the head and spine. He is Associate Professor of Neurological Surgery in the School of Medicine.

More than 35 members and guests attended the program.

* * * *

LOGAN

Dr. Richard E. Flood of Weirton, President of the West Virginia State Medical Association, was principal speaker at a joint dinner meeting of the Logan County Medical Society and its Woman's Auxiliary in Logan on November 9.

Doctor Flood outlined plans for the Centennial observance by the State Medical Association. He also said doctors must become more familiar with the various aspects of government medicine.

Nominations were made for new Society officers, who will be elected in December.

More than 15 doctors and their wives attended the meeting.

Dr. Thomas P. Long of Man, Acting President of the Society, presided at the session.

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KANAWHA

Mr. Harley J. McNeal, a Cleveland attorney, was guest speaker at the 15th annual joint meeting of the Kanawha Medical Society and the Kanawha County Bar Association which was held in Charleston on October 18.

"Malpractice legal actions against practitioners are not arising from declining professional standards among doctors," Mr. McNeal said. "People are becoming more insurance conscious. They think every policy has a benefit attachment."

Mr. McNeal advised the physicians to read the fine print in their insurance policies or "get a good lawyer to explain it."

About 150 doctors and lawyers attended the joint meeting.

* * * *

MERCER

The Mercer County Medical Society met jointly with the Mercer County Bar Association at the West Virginian Hotel in Bluefield on October 17.

Dr. Thomas B. Baer, the President of the Society, welcomed Mr. Owen Griffith, President of the County Bar Association, and Mr. Jim Imboden, field representative for AMPAC.

Dr. William F. Hillier, Jr., presented a panel discussion of whiplash injuries. Participating were Dr. E. Lyle Gage and Messrs. Norris Cantor and Owen Griffith.—John J. Mahood, M. D., Secretary.

RALEIGH

Dr. Robert W. Neilson of Bluefield was guest speaker at a joint meeting of the Raleigh County Medical Society, the New River Dental Society and the Pharmaceutical Society of Raleigh County in Beckley on October 20.

Doctor Neilson gave an interesting talk on his two months of service as a physician under "Project Vietnam." He used slides to illustrate his talk.

Drs. Lyle H. Boyea and K. H. Lee were elected to membership in the Raleigh County Medical Society as transfers from Logan County.—George A. Miller, M. D., Secretary.

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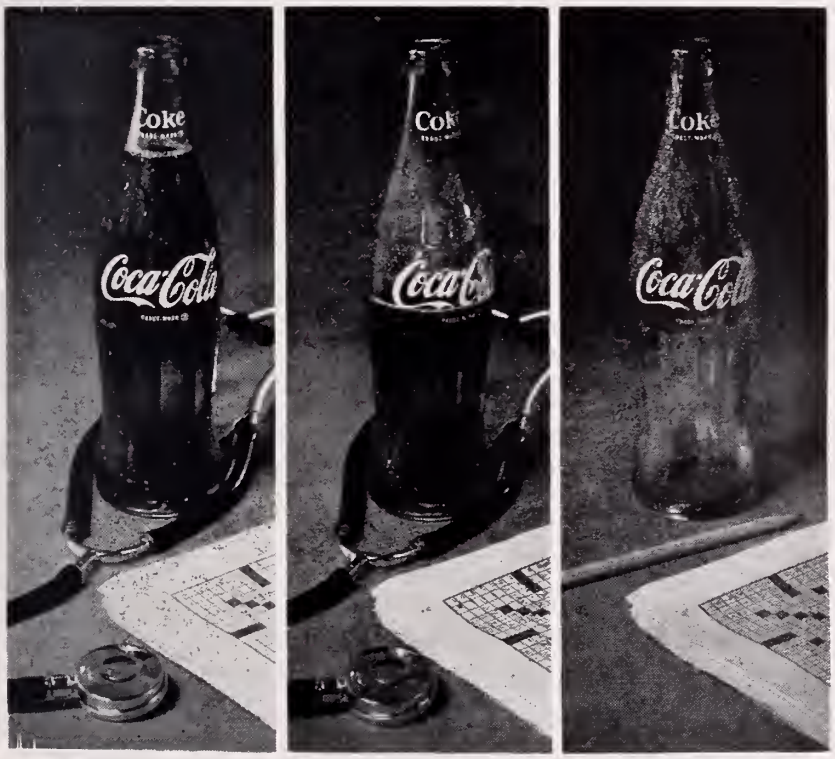

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HARRISON

A luncheon meeting was held by the Woman's Auxiliary to the Harrison County Medical Society at the Stonewall Jackson Hotel in Clarksburg on October 6, with 24 members in attendance.

Mrs. Lynwood D. Zinn of Clarksburg, a member of the Auxiliary, reported on the West Virginia State Medical Association's Rural Health Conference, which was held that day at Jackson's Mill.

McDOWELL

The Woman's Auxiliary to the McDowell County Medical Society held its regular monthly meeting at the home of Dr. and Mrs. A. J. Villani in Welch on October 12.

Mrs. R. H. Edwards was co-hostess.

A dessert luncheon was served to 13 Auxiliary members who brought articles to work on for the International Health Committee Services.

The Auxiliary made plans for a joint meeting with the McDowell County Medical Society in November.—Mrs. C. F. McCord, Secretary.

* * * *

MERCER

Mrs. Hu C. Myers of Philippi, President of the Woman's Auxiliary to the West Virginia State Medical Association, was a guest at the regular monthly meeting of the Woman's Auxiliary to the Mercer County Medical Society which was held at the Y Center in Bluefield in October.

Mr. James Imboden of Columbus, Ohio, field representative for AMPAC, was guest speaker.

Mrs. John J. Mahood of Bluefield, President of the Auxiliary, announced the appointment of committee chairmen.

* * * *

RALEIGH

Mr. I. Van Mynes of Oak Hill, an interior designer, was guest speaker at the regular monthly meeting of

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the Woman's Auxiliary to the Raleigh County Medical Society which was held in Beckley on October 18.

He discussed new trends in interior decoration and answered a number of questions.

BS-BC Attorney Discusses Medicaid Program

The second chapter in the story of New York's so-called Medicaid program may be even more intriguing than the first, according to an Albany, New York, attorney.

Addressing the Annual Program Conference of the National Association of Blue Shield Plans in Chicago, Joseph Boochever, LL. B., an attorney for Blue Shield and Blue Cross in New York State, observed that confusion and controversy over implementation of New York's Title 19 "Medicaid" program have been built up over the fact that the benefits furnished under the bill are so broad and that the federal government has still not approved the program.

"Although the law covers every medical need a person could require, the comprehensiveness of the coverage was not really the reason for all the excitement," Boochever noted. "What caused all the clamor was the estimate of the number of people who would be eligible to obtain benefits under the bill, and the projected cost of the program."

The federal law sets no eligibility standard, but the New York program provides that the scale begin at a maximum net income of $2,900 for a single person and $4,000 for a couple.

The original estimates on the number of persons who would qualify for coverage varied between six and eight million which would include between 40 and 50 per cent of the entire population of the state.

"An actuarial study made by the New York State Blue Cross and Blue Shield Plans projected an annual cost to New York State, before any federal reimbursement, of 1.4 billion dollars for the program when it became fully implemented," he said.

Despite the growing realization that New York's program could in subsequent years cost between 2.5 to three times the amount of the Governor's projection for the first year, he continued, only four amendments were passed in the closing days of the state legislature.

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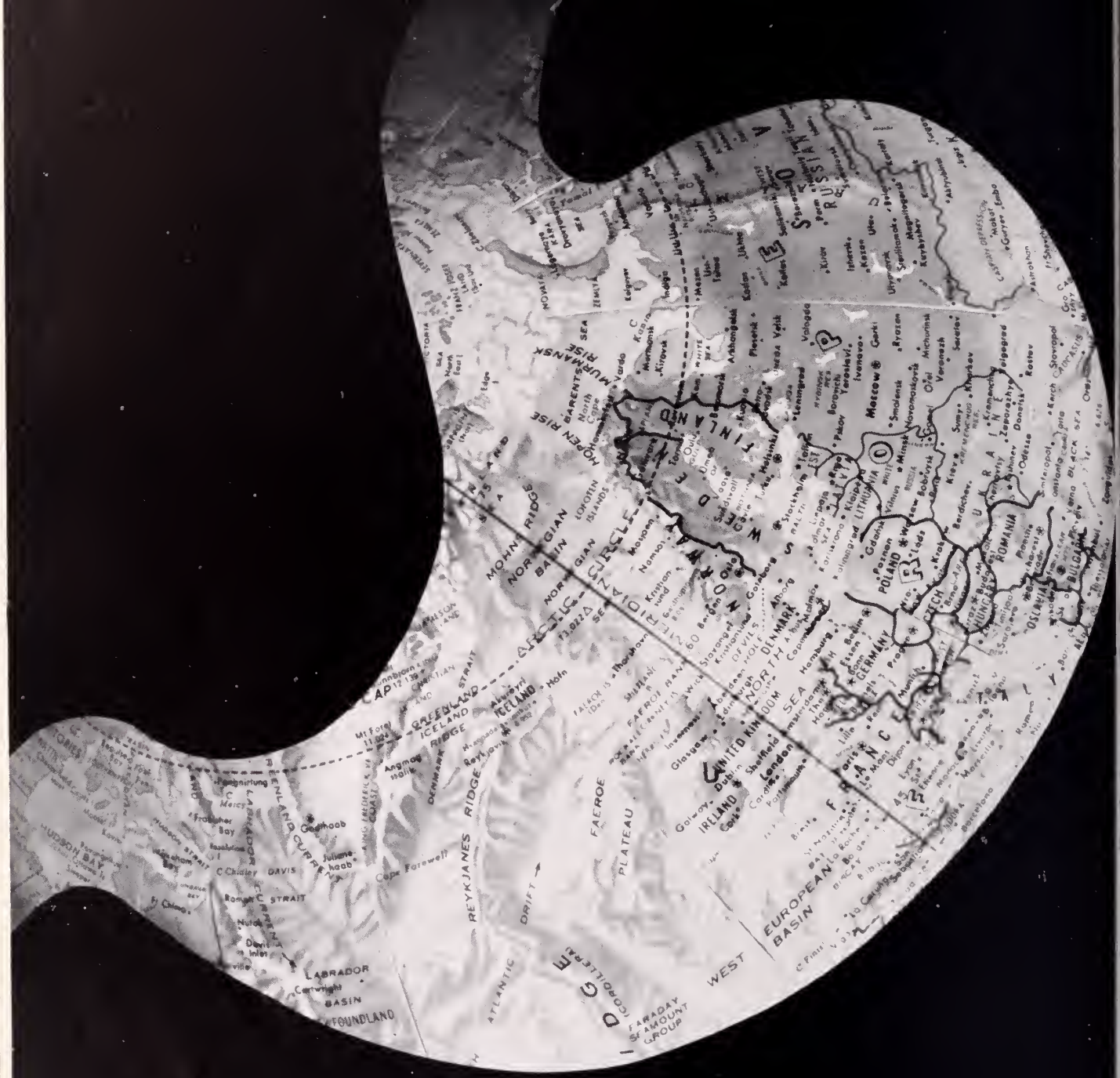

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Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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Book Reviews

THE NEW WAY TO LIVE WITH DIABETES: A COMPLETE GUIDE—By Charles Weller, M. D., and Brian Richard Boylan. Doubleday & Company, Inc. Garden City, New York. 1966. Pp. 131. Illustrated. Price: $3.95.

A variety of books and pamphlets are available to aid diabetic patients and their families in understanding this disease. Many of these are no longer valid because of the newer discoveries in this field. In this recently published book the authors consider diabetes as not one but a group of similar diseases with varying manifestations and therapeutic approaches. Three basic types are recognized: insulin-dependent, overweight, and stress diabetes. The major portion of the book is concerned with amplifying these concepts and discussing the management of various special problems of diabetes. Stressed is the fact that patients with diabetes especially must learn to understand and manage their own disease. Brief mention is made of the historical aspects, heredity and other predisposing factors, as well as diagnostic symptoms, signs and tests. Diet lists are included, although not in detail.

The authors appear to have touched most of the points relating to the practical aspects of diabetes. Some of their conclusions may seem a bit dogmatic but this is undoubtedly necessary (and desirable) in a guide of this kind. More emphasis might have been placed on the hereditary predisposition to diabetes and the patterns of prediabetes and chemical diabetes. However, these are minor criticisms. A somewhat more detailed explanation of diabetes diets, and especially the exchange system, should have been included.

Doctor Weller is a recognized authority in diabetes. The book is attractive, concise and well written. There is an adequate index. The print is large and the price is modest. I believe physicians could well recommend this book as supplemental reading for all concerned with diabetes who desire a better understanding of the nature and control of this fascinating disease.—Lyle D. Vincent, M. D.

★ ★ ★ ★

DISEASES OF THE HEART—By Charles K. Friedberg, M. D., Associate Clinical Professor of Medicine, College of Physicians and Surgeons, Columbia University. W. B. Saunders & Company, Philadelphia & London. 1966 Pp. 1787. Illustrated. Price: $22.00.

This is the third edition of an old and reliable text on heart diseases. There are 1800 pages in one or two

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volumes. The section on graphic methods of examination has been greatly enlarged to define and describe all the newer developments in this field of medicine. The section on circulatory failure is also much more voluminous than the second edition. It is a book in itself with 450 informative pages. The bibliography and index are excellent; however, illustrations are small and infrequent.

All practitioners can use this text frequently for diagnosis and treatment of all types of heart disease. Statements are not dogmatic and the reader is left with a choice of procedure according to his own interpretation of the illness. Coronary heart disease is treated exhaustively. There is a small, but sufficient section on surgical procedures in the cardiac patient.

The final chapter on insurance and medico-legal problems in cardiac disease and disability in heart disease is incomplete and too brief. In this era of insurance medicine most physicians need more instruction concerning the paper work of cardiac disability. The two volume work is more easily handled. The reference should be sufficient for research and teaching purposes.

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The West Virginia Medical Journal

Vol. 62, No. 1 January, 1966

Let's Take a New Look at Asthma*

Ethan Allan Brown, M. R. C. S., L. R. C. P.

The generalist who faces a new asthmatic patient usually experiences a feeling of dismay. He sometimes wonders how he can politely refer the patient to the colleague whom he most dislikes. To accept the patient for treatment is to become enmeshed in a life-long and often unrewarding relationship in which the responsibilities are out of proportion to the gratifications.

In this communication I propose to present a point of view which makes of asthma a "field" disorder. The reader will be obligated to learn the connotations of four new terms of which he now knows some of the meanings. The various fields will be shown to be reciprocally related, and asthma will be seen not as an effect but as a state which is both a symptom and a symbol. It will be seen that the fields, depending on the circumstances, can change in their value and that because there are many types of asthma there are multiple methods of treatment, each of which is correct for the one type of asthma and may fail when applied to any of the others, although there are some methods of treatment effective for many asthmatic patients. I know of no aspect of medicine which is more choked up with false notions as to cause and effect. In the space allotted to me I can discuss only the most flagrant of these notions.

Words, Words, Words

It is fun to play with words, but it ceases to be funny when an asthmatic patient is the victim of fallacious thinking. There are terms, for example, "exudative diathesis," which continue to be used. They are meaningless and serve only to conceal ignorance. Exudative diathesis is no more than a modern phrase for what was thought to be a discharge of humors or of moisture. The texts will also mention asthmatic patients as hyperthyroid because at one time it was thought that those who produced more thyroid hormone than was normal were over-responsive to external stimuli, to which they reacted with an outflow of mucus. The "dry" asthmatic patient was termed "tetanoid" because he presented a picture of more spasm and less mucus.

Equally devoid of meaning as applied to asthma are the terms "intrinsic" and "extrinsic." The first of these was a label applied to those patients who were allergic to pollens or to animal danders. It was admitted that they would not react with bronchospasm if they did not differ from the non-asthmatic patients in somehow being "intrinsically" different, that is, allergic. As we learned more and more of the external or atmospheric causes of wheezing, many of the formerly intrinsic asthmatic patients were seen to be extrinsically so. The term was reserved for those who wheezed for no apparent cause or because of the presence of infection or emphysema. As soon as either appellation was employed, the door to further investigation was closed. To be intrinsically asthmatic meant that the cause resided within the patient and was beyond either discovery or treatment. What nonsense!

The asthmatic patient is sometimes referred to as "susceptible" to infection or to the effects of the inhalation of pollen. How does the writer know that the patient is susceptible? Obviously

The Author

- **Ethan Allan Brown, M. R. C. S., L. R. C. P., Director, Asthma Research Foundation, Boston and Marshfield, Massachusetts.**

*Presented before the 13th Annual Scientific Assembly of the West Virginia Chapter of the American Academy of General Practice in Wheeling, April 30-May 2, 1965.

Submitted to the Publication Committee, June 7, 1965.

because he reacts with asthma! Why does he became asthmatic? Because he is susceptible. When he does not react with overt bronchospasm he has become what is referred to as "resistant." There are human beings who are ill and other human beings who are not ill. We will do the practice of medicine a great service if we cease to say that the former are susceptible and the latter resistant.

The most pernicious of all doctrinaire remarks is the phrase that the patient may "outgrow his asthma." The patient must suffer from a diminution of at least 15 and as much as 30 per cent of his forced expiratory volume before he senses a "tight feeling" across the anterior thoracic wall. He feels that he cannot take a full breath. A greater diminution of the vital capacity for the first and third seconds and the total amount forcefully expired by a cooperative patient may lead to wheezing not sensed by the patient but audible by the stethoscope. A patient who complains of wheezing may tell us that he was well before it became obvious to him, but we know better. In fact, he may say that despite the mild wheeze he feels well. He has divorced himself from his asthma.

We do not ask a diabetic patient how much sugar there is in his urine or what his glucose tolerance curve may be, and we are not led astray by the euphoria of the hypertensive patient whose good spirits are often an indication of an increase in his hyperpiesia. Patients who have not been treated but who have "outgrown" their asthma will, at an earlier age than their contemporaries, present themselves with emphysema and chronic bronchitis and all of the sequelae of untreated asthma including cor pulmonale.

The normal subject will not show an increase in vital capacity should we give him an injection of epinephrine or a tablet of ephedrine, either of which will in the "asthmatic-non-asthmatic" lead to restoration to normal values of the pulmonary functions. It is true that by our presently crude laboratory standards and between exposures or infections of the pulmonary tree, the patient who has supposedly outgrown his asthma may appear to be normal. I have observed such patients for periods of more than 30 years. They have outgrown nothing.

Anybody can be made to wheeze. He does not thereby become asthmatic. There is a difference between an asthmatic patient who is allergic to drugs and a normal patient who is allergic to one drug and avoids exposure to it. His is a special type of allergy. He cannot be said to suffer from what is ordinarily thought of as atopy or an allergic disease.

Every human being grows into every disorder from which he eventually will die, although in 15 per cent of the patients who die we never discover the cause of death. We can treat people "out" of the disorders they present but nobody ever outgrew anything because everybody grows older second by second and the only alternative is, for almost all of us, not a pleasant one to contemplate.

Constitutional Factors

Everybody who is exposed to viruses or bacteria does not become ill although there are those in whose cases it can be proved that they have succumbed in a mild or subclinical manner appropriately termed "forme fruste." It seems to me that with the exception of the inborn errors of metabolism all of us are constitutionally or genetically subject to the ills we suffer from or that none of us is. Few human beings are constructed like the one-horse shay.

It seems to me that once more, given the peculiar structure of our language, we are playing with words when we say that the asthmatic patient is the possessor of or is cursed with a particular constitutional factor and that when a given quantity of an environmental stimulus exists, he reacts with bronchospasm. It is clear that such thought processes differ little from medieval and demoniacal concepts of disease.

We do not seem to mind that we do not know why an electron of the inner shell of lithium vibrates 10^{17} times each second or that the inner electrons of gold vibrate more frequently each second than the number of seconds which have elapsed since the estimated birth of the universe. We somehow insist on ascribing a cause for asthma which we look upon as an effect instead of as a state. We do not realize that we are retreating into darkness when we satisfy our ignorance with the creation of a constitutional factor, an external substance or stimulus and an imagined relationship between the two. If we said that we did not know why some human beings wheeze when exposed to pollen and why some do not, we would be looking forward to causes which are used to explain and reasons which help us to understand rather than to empty phrases which do neither.

A Logical Look at Asthma

A physicist who examined a number of asthmatic patients, no matter how the bronchospasm was mediated, would say that asthma was a "field" disorder. Physicians have been known to

employ the term, "multifactorial," which is, however, a precise concept related to a continued product of factors derived from a function by increasing or decreasing constants. This is as distant from our meaning as it is from our understanding.

Instead of employing the vocabulary of the physicist we may use the parallel terms of the logicians which may appear, momentarily, to be strange, but which will repay us many times over for the minutes we spent in learning this meaning.

Anything which exists primarily in time and secondarily in space is an existent. An existent is also known as a substantive. There are substantives which exist for extremely short periods of time. There is Planck's Constant, a quantity or quantum of energy. It is equal to 6.55×10^{-27} that is, 6.55 ten thousandths of a trillion trillions of its particular dimension. For our purposes, a patient is a substantive.

Our present use of the word "state" was first defined, strangely enough, by Machiavelli. Living beings are organized and exist as successive series of states. Any substantive which continues to exist while its states or relations are changing or may be changing is known as a continuant (Johnson). If there were no substantives there could be no continuants and a continuant is therefore a subclass of substantive of which another subclass is an occurrent.

No matter how different or unrelated such occurrents are to each other they achieve a particular unity as they are referable to a particular continuant. A patient may, for example, pollute the air of his lungs by smoking, or his home by use of an aerosol bomb or by painting the walls. There may be out-of-doors pollution because of automobile exhaust emissions. Their effects upon the patient relate all of the occurrents to each other.

Occurrents may be temporal or spatial although the concepts overlap. An inhalation of burning bacon obviously is temporal, while the mold spores of the vegetation and the air of a large area of land can be considered as spatial. For the asthmatic patient, time and space often are interchangeable. If he leaves his home environment during the pollen season for another where the pollination has not yet occurred, or is over, he has substituted space for time. If he departs from his home environment before the pollen season and goes into an area in which the same pollen to which he is allergic has appeared, it is as though he had advanced in time the pollen season of his home environment.

When the asthmatic patient stands in the center of his own homeostatic field, it is realized that physical occurrents may affect him from within himself or from outside his body. Occurrents may not be only physical, but psychical. Either of the two may lead to the same asthmatic state, but a physical cause is not the equivalent of a psychic determinant.

A psychical occurrent is thought of as taking place in the brain or the nervous system, and is named an experient. An experient may be the result of an occurrent outside of the body as when a parent dies, and as a psychical occurrent within the body as it represents the patient's reaction to death. An experient may be objective when it manifests itself as a true claustrophobia should the patient find himself in close quarters. It may be subjective when a patient introjects an imagined claustrophobia to his lungs or thorax, or both. The interrelationship and interaction of physical and psychical occurrents may be most subtle as when an asthmatic patient suffers from an anxiety neurosis which often is defined as a physical manifestation of a psychic deprivation or else from a classic type of hysteria which is a mental or psychic manifestation of a physical deprivation or depression of function. A somato-psychic relationship is similarly seen in the deep depression experienced by patients who suffer from pancreatic disease.

It is not true that psychotic patients are free from asthma, although the two disorders are uncommonly concurrent. The true psychotic disorders may be likened to multiple-stage rockets which are in free flight. In almost every instance the psychotic has successfully cast off his booster or first stages. He may not have been successful, in which case he carries them with him and appears to suffer both from psychosomatic and psychotic disorders.

The Patient and the Field

It is most illuminating to think of the patient as a small circle within which he is subject to the changes of homeostasis and to the failures of feedback mechanisms. As to this last, his respiration should normally be mediated by a set of complex controls almost all of which are chemical in nature, although breathing is also related to a fight or flight pattern. The asthmatic patient breathes good air as though it were foul. He inspires air as though it were in short supply. He cannot quickly enough get the air into his lungs from which he appears to have difficulty in expiring it. The greater his apparent effort to get the air out of his lungs, the more spasm of the

bronchi he engenders and the greater the mucous membrane edema.

I have regressed patients under hypnosis to infantile breathing patterns so that respiration was chemically mediated, and have terminated status asthmaticus of three weeks' standing in ten minutes and without the use of any drugs. When the asthma is caused by inhalation of pollen or the wheezing is the result of an infection (two types of occurrents which are known as occupants), there is little response either to hypnosis or tranquilizing agents. Those who attempt to evaluate the uses of drugs in the asthmatic state and who are not familiar with the framework described do not always understand why their results are so inconsistent.

Within his own small circle and independently of outside forces or factors, the patient's asthma either may be a learned response or the result of conditioning. He usually is not aware that he can wheeze more and more for less and less cause until he reaches the stage when merely checking himself to discover whether he is wheezing brings on an attack of asthma. A patient who is allergic to cat dander may be hyposensitized by means of injections of a potent extract administered in appropriate quantities. He will then not wheeze in the presence of a live cat or in an environment in which, unknown to him, a cat has been present. A patient who has been conditioned will wheeze when he sees a stuffed cat although its fur is free of dander. Both types of asthma are similar but not identical. They may exist in the same patient or one or the other may be present.

Each of the occurrents may be pictured as an ellipse. As is generally known, an ellipse is a geometrical figure which has two foci. The focus of each ellipse incorporates the small circle which represents the patient and his homeostatic processes.

One ellipse may represent all of the airborne pollens or molds or, if the patient is allergic to several successively appearing seasonal pollens, then there should be three ellipses. The end of the season of one may overlap the beginning of the season for another as when the patient is allergic to the pollens of the trees and the grasses, or to the grass pollens and those of the weeds. In the northeastern part of the country the ellipse for the weeds would overlap the ellipse which represents sensitivity to house dust to which there is greater exposure from September to May than during the summer months. When the patient is allergic to two overlapping pollens or inhalant substances, half the quantity of each will result in a degree of asthma as severe as twice the quantity of either.

It is the purpose of the detailed and meticulous history to discover how many ellipses there may be. One may be reserved for food allergy although it is uncommon, and another for viral infections, and a third for bacterial infections of the lungs. For polluted air which may carry ozone, carbon monoxide, sulphur dioxide, nitrogen trioxide, a large ellipse may be pictured, or if the patient responds to individual pollutants, each may warrant its own separate figure. A patient who smokes cigarettes and inhales places many of the same and a number of other air pollutants directly into his lungs in quantities which are greater than those permitted in industry. The patient who smokes carries his polluted air with him. He must run far if he wishes to escape from the effects of externally polluted air of modern cities, especially Los Angeles. The patient who does not inhale nevertheless takes in the smoke which he exhales with the respiration between puffs of his cigarette. He is not much better off because he does not inhale. He has a right to unpolluted air and should insist on it, especially when its result is debilitating illness.

Asthmatic patients are especially affected by precipitous drops in external temperature or to the inhalation of cold air. The many phenomena associated with drops in barometric pressure will also tend to cause wheezing. When they have been taught to read a weather map and take medicine in anticipation of changes in temperature and barometric pressure the patients can lessen if not avoid attacks of bronchospasm.

The physician interested in the treatment of an asthmatic patient cannot possibly know too much concerning his environment, whether at home or at work, his habits, hobbies, diet, what he drinks and how much and how often, and the presence of other disorders concerning which inquiry should be made. Most important is the patient's image of himself and how close to a realization of it he comes. The more ellipses or fields of influence the physician is aware of, the more he understands the reasons or causes of any one attack of asthma.

The Multiplicity of the Fields

The good asthmatologist quickly realizes that the asthmatic patient is commonly subject to other disorders which he hardly ever, if ever, mentions because to him his fight for breath is the most important of all his disabilities. He may lightly wave away questions as to peptic ulcer

(often present in the emphysematous patient), bouts of dizziness or vertigo or drug allergy or unusual responses to the administration of drugs. He is so often overly reactive to placebos that to him they become "nocebos." In female patients, a delayed period or a pregnancy may result in an exacerbation, although there are patients in whom a pregnancy is a period of lessened asthma, except for the six or eight weeks after delivery. Precise measurements will demonstrate that asthmatic patients who are not being treated with corticosteroid hormones are often glycosuric, but not diabetic.

The lessening of the frequency or the severity of the attacks of asthma by the use of drugs taken continuously often will favorably influence the states of the other disorders which, usually in their own right, require treatment. Such treatment will also lessen the degree of bronchospasm. In making this statement I am merely making a plea not necessarily for a holistic approach to the treatment of the asthmatic patient but, rather, emphasizing the need for comprehensive treatment, which embodies more than an awareness of what are termed body-mind relationships but, rather, many body-body relationships which may be of equal or greater importance.

The Symptom as Symbol

In the field of asthmatology every attack must be examined more than once because it may not be what it seems to be. If we forget that the asthma may be either a symptom or a symbol as well as a sign, we will not seek pseudosolutions to pseudoproblems and, in the process, either lose sight of the patient or fail to understand what is going on.

When our patient is of the manipulative type and either the physician or circumstances makes it difficult or impossible for him to manipulate people or things, we will discover ourselves recording an otherwise puzzling increase in the frequency or severity of the asthma. Should we make it too difficult for him to wheeze he will present us with a number of equivalents of asthma of which we may, at first, be unaware.

There are asthmatic patients who wish to live limited lives. They lack insight or do not possess the authority to limit their own activities. When we impose limitations or eliminations which limit them, it is not what we limit but the act of limitation which is important and which results in improvement. Any other form of limitation would have done as well. Those who have been forced to live restricted lives may crave more activity. When we permit them to do more than they have been doing, it is not the activity we choose but the permission to flower into a full life which leads to less asthma.

A boy who does poorly in sports may request a note excusing him from physical education. Another who has been prevented from joining in games will not improve until he is permitted to engage in competitive sport. The first of the two boys may exert as much effort in another activity and not wheeze, while the second may wheeze when faced with less exertion in which he does not wish to join. A patient who desires to be a veterinary physician or a physical therapist (two manipulative occupations) will do well despite sensitivity to animal danders if it is understood that if they cause difficulty the patient must engage in another type of occupation.

An asthmatic child who feels at home with other asthmatic children will do well in a convalescent home which limits its occupancy to those who wheeze. Should we send a child who loathes being asthmatic to such a home he will grow worse, commit suicide, or die. If we are routinely either authoritative or permissive we will fail to treat some of our patients adequately. Superficially, every patient acts as though he wished to be free of his asthma. To some patients the asthma is useful as a means of manipulation. They are not treated for their asthma, but rather by a maturing process so that the wheezing is no longer needed because they learn to accomplish their aims by what are socially acceptable methods.

The Fields Change in Value

In poker, one jack may be worthless but two jacks serve as openers. In bridge, the winning bid establishes trumps. In checkers, a piece may become a king. In the general practice of medicine we recognize a number of such changes in value as when one patient does and another does not wish to become well. The same infection may affect both and the treatment consists of the one antibiotic agent. The results are not equal. Investigative studies prove that a subject who is a placebo reactor in one situation is not a placebo reactor in another. When we wish to investigate the effects of analgesics, we learn that contrived pain is not at all equivalent to the true pain, for example, of a renal calculus. An older patient who is tired and has resigned himself to death will accept agonizing pain which no younger patient who has a reason for living would ever undergo. The divergent gestalts of the delivery of a wanted and an unwanted baby must be seen to be believed.

The asthmatic patient's standards change within his own home circle. Should he have been

well for some time and then because of an exposure to fumes or a noxious gas suffer from asthma he will comment that "he is back where he was at the beginning of his treatment." During a season when he has had no treatment for his pollen asthma, it is remarkable how much discomfort, which is of his own doing, he will uncomplainingly suffer, but should he take some injections of extract, then any wheeze, no matter what its cause, is an emergency requiring immediate treatment. It is for this reason that I usually treat a patient who is allergic to the chief pollens of an area with the secondary pollens, although they are ambient for only a few days at a time and do not cause serious effects. Should these causes of discomfort be omitted, the patient will complain that his treatment is a failure despite a record which proves a diminution of symptoms from eighty to perhaps three days.

Outside of his home circle and in the areas of the ellipses the values also change. In an untreated allergic asthmatic patient, exposure to a little pollen early in the season will be the reason for symptoms much more severe than later during the season when there is exposure to many multiples of the quantity of pollen to which the patient has, however, been exposed in gradually increasing quantities. If the maximal amount of pollen in the air were to be present during the first days of the season, exposure would be catastrophic in its effects. What is termed "hardening" is no more than a change in value.

If, in addition to exposure to little pollen, there is an increase in the amount of air pollution or if there is a sudden drop in temperature, the asthma will become more severe than if any one or two of these factors were present rather than all three. A sudden increase in the amount of ambient pollen will create havoc among asthmatic patients, all of whom will react similarly although they do not know each other. It may have rained for four days but grief and attendance at a funeral at which there are no flowers will result in asthma much more responsive to sympathy and understanding than to drugs.

A so-called impartial evaluation of a method of treating asthma, for example, by injections of extract administered by one or another of two methods and related to the pollen count, is an exhibition of scientism rather than of science. Pollen slides, not placed on a window ledge where the patient does not reside for eight weeks, but attached to the lapel of the patient's coat or dress will demonstrate differences of exposure which may vary by a factor of 1,000 and, in some instances, 10,000. The pollen slide cannot measure the intensity of exposure, that is, the number of pollen grains inhaled in a given period. This exposure may be represented by minutes or by all of the hours of the day.

Nowhere is the overlapping of the fields and their changes in value more obvious than in the three aspects of treatment by means of extracts. The asthmatologist controls the quantity of extract he injects. He may not know that the extract may have lost some of its potency, but he does know whether he is treating the patient with all of the pollens to which there is sensitivity. He knows that if he injects too little extract the patient will undoubtedly be ill, and that if he injects too large a quantity he will give the patient a systemic reaction. There are no units of measurement for the potency of the extract. Only by experience can he learn how much the patients of his area require as regards the quantity of extract.

No matter how experienced the physician may be, there is no present method of measuring the response to treatment by an individual patient. It is not practical to expose the patients to the pollens in a framework similar to that which they encounter during actual exposure and under the conditions imposed by the natural history of the disorder. A pre-seasonal whiff of pollen from the flat end of a toothpick is as distant from natural exposure as a drill in boot camp is from actual battle.

The third factor consists of both the amount and the intensity of the exposure as modified by other factors as humidity and temperature, and also the patient's state of well-being. We cannot employ the skin test response as a measure of sensitivity because it is done with the same extract which we plan to inject, and what happens on the skin with the fixed "antibodies" is quite different from what results from the interaction of circulating antibodies which, if they exist, are not the same because in a successfully treated patient the skin test response may be no less and in some cases may be greater than it was before treatment was initiated. It is clear that a given patient less sensitive than another, when exposed to more pollen for a given time or to less pollen but more intensely, that is, for a shorter time, will respond exactly as does the more sensitive patient who is exposed to less pollen for the same length of time.

A patient who has been afflicted with pollen asthma for 10 years will take all of 15 minutes to recount his history. We treat him for an unknown future on the basis of an in-

definitely described past which may have been maximized or minimized or associated with restricted activity which the patent will not impose on himself once he has taken his injections. We treat him for one disorder, but he presents us with another. During the previous pollen season he took a deep breath and ran from his air-conditioned home to his air-conditioned car and then took another deep breath to run from the car to his office. After he has taken his injections he plays golf three times weekly.

These examples of the changing values of the treatment of an allergic asthmatic patient demonstrate the fact that allergy is a practice and not a science, and that only by experience coupled with knowledge outside of the field of allergy can one allergist do better than another. The one knows why his patient is wheezing during the pollen season and is aware of the fact that the symptoms are not the result of inadequate treatment by means of extract. The other may conclude that the treatment by means of extract was not successful.

The Reasons for Multiple Methods of Treatment

Physicians who do not, as a rule, treat many asthmatic patients are puzzled by the literature which describes successful results achieved by divergent modalities. They may incorrectly conclude that all asthma is psychogenic. The psychiatrist who omits the possibility of allergy will often treat patients in vain. The allergist who will not listen to his patients but rather limits himself to tests and injections will only partially relieve the symptoms of great numbers of them. The asthmatic patient needs the modality most suited to him and more often several types of treatment.

The patients who need the arsenicals are few and the drugs are dangerous and, in fact, treacherous in that they will be effective for long periods and then act as toxins. I do not prescribe them, if only because of fear, but one of my colleagues does. He is careful in choosing patients for this type of treatment, and those who otherwise have been unresponsive are symptom free. Some of my patients apparently have responded favorably to sympathectomies, neurectomies and to glomectomies, although there are no obvious changes in the results of the pulmonary function studies. This is no cause for concern. I have seen too many patients whose lung functions showed improvement while they wheezed, and have seen the same patients return with lower vital capacity readings for the first and third seconds and the total, and yet be free of symptoms. Any test which depends on patient cooperation and forceful expiration will lead to bronchospasm so that it is impossible to reproduce the measurements immediately after they have been taken. In some asthmatic patients the amount of cardiopulmonary recruitment is so great that the mere thought of undergoing the test diminishes the vital capacity and the maximal breathing capacity. When they have been taught how to exert themselves without tightening their bronchi and elevating their diaphragms, the results of the tests often are reproducible but not invariably so.

There are asthmatic patients who secrete too much mucus and in whose cases roentgenologic treatment directed to the hila of the lungs brings long lasting relief, some of which is also secondarily nonspecific. Those who most puzzle me are the patients who move to an area where the pollen count is supposedly higher and yet they do well. There are also patients who change their residence to low pollen count areas and suffer from more severe symptoms. Those who go to supposedly dry climate countries or areas do not often realize that other factors are operative. The humidity in their old homes, especially during the winter, was less than that of the dry climate to which they fled.

There are a few patients who are truly sensitive to foods. There are many others who will respond favorably to any diet which limits their intake of any foods. In some cases, there are food addictions which lead to unbalanced and often bizarre diets. There are others in which the individual foods are symbols. Some such foods will not be eaten and others will not be eliminated. The shell fish often are histamine-release foods. Given the framework they will cause asthma despite an absence of shell fish allergy.

There are asthmatic patients who gasp for air when they inhale. It will be noted that they breathe paradoxically. They will elevate their diaphragms as do those who suffer from too great a degree of cardiopulmonary recruitment but, in addition, these patients lessen the volume of the thorax. Rapid inspiration will narrow their bronchioles as much as will forceful expiration. Stethoscopically, there are both inspiratory and expiratory wheezes which change both in pitch and intensity. These patients can also be taught to breathe as they should or, failing an understanding of, what should be done, can be hypnotized and regressed to infantile patterns of respiration.

An occasional asthmatic patient cannot rid himself of his excess mucus, which is not affected

by expectorants, while his bronchial tree does not sufficiently respond to bronchodilating agents. Ether anesthesia and a lung "washout" not only will remove the excess secretions, but place the patient in a position in which he can easily cope with what are now "normal" quantities of mucus. Such patients enjoy months and sometimes years of remission and, if need be, after an infection the procedure can be repeated with the same good results. We have used it in patients who raise typically yellow-green mucus and who have not responded favorably to antibiotic agents.

It would be too difficult a task to list all of the different types of asthma and the treatment of each, especially when the patient contends that the drug which was previously effective no longer relieves his bronchospasm. The medications which keep an allergic asthmatic patient comfortable are ineffective when the patient suffers from bronchitis, for which the treatment is totally different.

The New Look

Granted that the asthmatic patient does not present himself in so severe a state of bronchospasm that he needs heroic treatment, the physician, although not an asthmatologist, need not be dismayed. The various physical causes of wheezing are listed in every textbook of medicine and are described in all of the tomes which limit themselves to the subject of allergy. There are tables of differential diagnoses which are easily learned. It is not difficult to rule out any one or several by the correct questions as supported by laboratory procedures which are neither complex nor time-consuming, nor expensive. The framework which has been presented may at first repel, but no more so than a map of a new territory with which the physician is, as yet, unfamiliar. Given a logical structure, the attendant physician can, with some assurance, move from the consideration of one aspect of asthma to another and be certain that he is neglecting few, if any.

Exposure to some occurrents may be eliminated or minimized. It is sometimes difficult, impractical or impossible to remove the patient from a particularly harmful environment. Injection treatment will lessen the effects of exposure to some of the inhalant substances which cannot be removed from the environment of the patient.

All of us are subject to the ordinary stresses and strains of the living process. Some of us can take them in our stride, while others relate them to body systems and after a varying period of adaptation react with peptic ulcer, hypertension, diabetes, migranoid or other types of headache or vascular disorders. It has been said that it is not what the peptic ulcer patient eats, but rather what is eating him that is responsible for his ulcer. It might just as easily be affirmed that the asthmatic patient takes things to heart and to his lungs. Inasmuch as emotional experience cannot be avoided, eliminated or swept out of the way, the patient must be taught that his respiratory processes (when they are not entirely allergic and limited to one season or infective and present only when he is bronchitic) need not be affected by what he intends to do, is doing, is thinking or is recalling. We must learn that everybody to some extent relates his experience to his breathing. The asthmatic patient tends to overdo it. If he is to remain well he must be taught or must learn, if anything, to "underdo" it although, as one of my patients discovered, he has to hold his breath for two minutes.

New Drug Score: USA 75, USSR Zero

HOW important is the patent system to the prevailing health care picture? Here are a few examples. In 48 years, Russia's government-owned pharmaceutical industry has not developed a single new and important drug. In 24 years, thanks in part to patent protection, the American pharmaceutical industry has come up with at least 75 new drug entities. Credit (and a considerable amount is due) must go to a competitive industry that thrives in a competitive economy—motivated by the rewards and contributions to knowledge that the nation's patent system has always guaranted.—Editorial in GP.

Special Therapeutic Considerations In Congestive Heart Failure*

John H. Moyer, M. D., and Robert L. Capizzi, M. D.

During the clinical course in many cases of congestive heart failure, a time comes when the patient no longer responds to routine and time tested therapeutic measures. Frequently the patient is elderly, has had frequent exacerbations of chronic congestive failure, and seemingly has responded fairly well in the past to established methods of treatment. It may then be very tempting to assume that his current condition is the inevitable sequel to his basic disease process, be it atherosclerotic, hypertensive or rheumatic heart disease, that finally he has reached an irreversible stage of his progressive myocardial disease. Although frequently this is the case, it may not always be.

Several adjectives have been used to describe this chronic congestive heart failure which does not respond well to treatment, namely, resistant, refractory, and intractable. For the purpose of this discussion, we shall use the term "resistant" to describe heart failure that has become difficult to treat. "Refractory" will refer to the type of heart failure which, while not responding to routine therapy, still may respond to special methods of treatment. "Intractable" will designate the type of heart failure seen in the case in which the condition has deteriorated beyond the point of effective response to any therapeutic measure.

Within the past decade much effort has been expanded in determining the causes of cardiac failure at the cellular and subcellular levels, and a biochemical concept of congestive failure has been postulated. Briefly, normal myocardial metabolism may be divided into three phases which are characteristic of muscle metabolism in general. These are: (1) energy production through the anaerobic and aerobic metabolism of foodstuffs, (2) energy storage through the formation of high energy phosphate bonds (oxidative phosphorylation) embodied in adenosine triphosphate and creatine phosphate and (3) energy utilization through muscle contraction, with the production of cardiac work.[1] Thus, phases 1 and 2 involve the oxidation of foodstuffs, with production and storage of energy until it is needed by the contractile proteins actin and myosin, and phase 3 is the transformation and delivery of this stored energy into the kinetic activity of the heart.

Danforth[1] and Katz[2] and their co-workers studied heart muscle fibers of patients who succumbed to heart failure due to prolonged overload of the heart muscle such as occurs in hypertension, valvular heart disease, or atherosclerotic heart disease. They found no defect in the production or storage of energy, but they discovered that the integrity of the contractile protein, actinomyosin, was impaired. The biochemical defect in heart failure that occurs in association with certain specific disease entities, however, can be identified somewhat more readily. As examples, the heart failure resulting from anoxia on the basis of anemia, coronary artery disease or hemorrhagic shock apparently is due to failure of energy production. Since insufficient oxygen is supplied to the muscle cell, aerobic metabolism is deficient. Consequently, the production of adenosine triphosphate and creatine phosphate is decreased.[1, 3] In heart failure associated with thyrotoxicosis, the chief biochemical defect is both in the production and the conservation of energy. Here, substrate utilization and oxygen consumption are increased, but the thyroid hormone causes uncoupling of oxidative phosphorylation, i. e., prevents the formation of high energy phosphate bonds, thereby interfering with the efficient use of oxygen.[1, 3] Beriberi heart disease is due to a deficiency in the cocarboxylase en-

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zyme, thiamine pyrophosphate, which is necessary for aerobic metabolism. When the supply of this enzyme is inadequate, the heart uses less oxygen and energy production is inadequate.[1, 3]

These examples of abnormal myocardial metabolic processes give some indication of why congestive heart failure sometimes might be resistant or refractory to treatment. Digitalis is effective primarily in heart failure that is due to chronic overload, with consequent impairment of the contractile proteins. It cannot be expected to correct an oxygen or enzyme deficiency, whereas specific therapy for this purpose in the form of blood transfusion, antithyroid drugs, or vitamin B_1 might bring about improvement in a seemingly intractable state of heart failure. This illustrates the importance of determining as accurately as possible the basic cause of the failure.

Differential Diagnosis

When we find that a patient apparently is not responding to such routine measures as rest, digitalis and diuretics, how should we proceed in attempting to help him? The first thing to do is to reassess the primary diagnosis. Once assured that the patient is in heart failure, it is incumbent upon the clinician to determine why. It is easy to inculpate atherosclerosis, hypertension, rheumatic heart disease or even cardiovascular syphilis when we find evidence of one or more of these conditions. The heart failure, however, may be due to less common and less obvious causes, some of which may be amenable to medical or surgical cure. The physician must be especially alert for such conditions when the patient appears to be in a refractory or intractable state of cardiac failure. Some of these are discussed in detail, together with appropriate specific treatment, following the discussion of therapeutic measures directed toward relief of the heart failure itself.

Only after duly considering all facets of the patient's condition and determining that he does not have a correctable condition or conditions that may be causing his heart failure should the physician turn his attention to a plan of therapy beyond that required for immediate relief of the acute symptoms. Then, after a thorough evaluation has been carried out, he should outline a complete therapeutic program. This should be planned with provision for adjustment as necessary to keep the patient out of failure at all times. If unusual measures appear to be necessary, the physician should be prepared to use them. Despite the many reports on iatrogenic complications arising from treatment of heart failure, the fact is that each year patients who die because of inadequate therapy greatly outnumber those in whom serious complications develop as a result of therapy.

Therapy: Routine Treatment

Rest.—All too frequently the patient will minimize the seriousness of his condition and attempt to ignore some of the restrictions that the physician has placed on his activities. The one requirement most often ignored is the need for restriction of physical and emotional activity. It is known that physical activity increases oxygen consumption, cardiac output and heart work[4] and, when unrestricted, can have disastrous results. With strenuous exercise, renal blood flow is reduced as well. Accordingly, in the case of the patient with heart failure, the added stress of exercise will aggravate the pre-existing reduction of renal blood flow and the attendant retention of salt and water. Emotional stress may have similar effects.

The posture assumed while resting also is important, especially for the patient in severe heart failure with retention of large amounts of fluid. Assumption of the upright or the sitting position has been found to increase significantly the vital capacity and lung volume.[5] At times, a change of posture alone will alleviate dyspnea and cyanosis, and even will produce substantial diuresis as a result of increased cardiac efficiency. This diuresis is physiologic; isotonicity of body fluids is maintained without preponderant loss of cations or anions.[6]

Salt Restriction.—Another important measure that should be employed in the management of such patients is salt restriction. Although concomitant use of the highly effective oral diuretic agents available today permits us to liberalize the salt content of the diet to some extent, it does not eliminate the need for control of the salt intake. Salt restriction still is of paramount importance in the care of patients with congestive heart failure, especially when the condition becomes difficult to manage. This is particularly true when diuretics are given intermittently. In these circumstances, the higher the salt intake, the more rapidly sodium and water will be retained after the response to each dose of the drug is lost and before the next dose is given. On the other hand, when the diuretic is given with adequate frequency, this secondary retention of sodium and water is not a problem. What constitutes adequate frequency is determined by the drug used, since the duration of action varies greatly from drug to drug.

The sodium content of the water is an important consideration. In certain areas of the

United States e. g., some western states, the water contains 2.5 to 3.5 Gm. of sodium salts per liter. Therefore, physicians in these areas must take the added precaution of specifying that their patients' meals are to be prepared with distilled water, and that these patients be given only distilled water for drinking. When a state of compensation has been achieved, the sodium intake may be gradually liberalized to 1 or even 1.5 Gm. daily.

Digitalis.—Ever since the days of Withering, digitalis has been a mainstay in the effective treatment of congestive heart failure. Unfortunately, its misuse, resulting either in overdigitalization and underdigitalization, more often than not is the underlying factor in what appears to be intractable failure. All too often, physicians proceed with great trepidation in the use of this important drug. Textbooks are replete with average digitalizing doses, yet there absolutely is no place in the proper management of congestive heart failure for the practice of prescribing the same digitalizing or maintenance dose for every patient. A given dose either may be inadequate or excessive for a substantial proportion of those for whom it is prescribed. For most patients, the proper dose of whatever form of digitalis is used must be determined in accordance with the classic dictum of Withering: ". . . let it be continued until it either acts on the kidneys, the stomach, the pulse, or the bowels; let it be stopped upon the first appearance of any one of these effects." Close electrocardiographic monitoring is the most convenient and reliable means for determining maximal dosage without cardiac toxicity.

Digitalis tends to improve the strength of the cardiac contraction. Qualitatively, the various digitalis glycosides are similar in their action and in the margin between the therapeutic and toxic dose ranges. The therapeutic effect of all the glycosides is attained at approximately 50 to 60 per cent of the toxic dose.[6] In the case of the patient with advanced heart disease, however, the therapeutic ratio is decreased, that is, the dose needed to produce a therapeutic effect is close to the toxic dose.[7] The cardiac effects of digitalis vary inversely in relation to the serum potassium level: when the level of potassium is low, these effects are increased; when it is high, they are decreased. Experimentally, a potassium deficit of 5 to 10 per cent lowers by 60 per cent the dosage of digitalis that will cause ventricular tachycardia.[8] This decrease in therapeutic ratio is especially prominent when the patient has been taking thiazide diuretics, which tend to cause hypokalemia.

Occasionally it is extremely difficult to determine clinically whether a patient with nausea, vomiting and some type of cardiac arrhythmia is suffering these manifestations on the basis of congestive heart failure alone, or whether he is overdigitalized. The acetyl strophanthidin test has been advocated by some clinicians but is hazardous unless it is administered by a physician who is thoroughly experienced in its use. There is no easy way to determine digitalis toxicity. When there is any question of whether or not the patient is receiving excessive amounts of digitalis, the history, physical findings and electrocardiogram must be evaluated simultaneously. Of the three, the history is the most important. Frequently the intravenous infusion of 50 mEq. of potassium with continuous electrocardiographic monitoring will give important information on digitalis toxicity especially if the toxicity is related to the depletion of the total body content of potassium. The serum level of potassium does not always reflect such depletion.

Further administration of digitalis is contraindicated whenever there is doubt as to whether or not the patient is overdigitalized or underdigitalized. This is because of the inherent danger of precipitating an uncontrollable arrhythmia, or even cardiac arrest, if additional digitalis is given.

Diuretic Therapy.—Several factors contribute to the edema that is so prominent a feature of chronic congestive heart failure. Because cardiac output is seriously impaired, the forward flow of blood is inadequate. Consequently, there is a backward accumulation of blood, which results in venous distention. The increased venous pressure predisposes to accumulation of water and electrolytes in all tissues of the body. The kidneys are particularly affected by the reduction in cardiac output since the amount of blood delivered to them under such conditions is disproportionately lower than that delivered to the rest of the body. Stasis occurs in the renal veins; in addition, pressure in these veins is increased as a result of the "backward failure." The amount of glomerular filtrate is greatly reduced. As this reduced filtrate descends the tubules, more than the normal amount of water and fixed base (such as sodium) is reabsorbed. The lessened glomerular filtration rate and increased tubular reabsorption of sodium and water (glomerulotubular imbalance) are of cardinal importance in the pathogenesis of congestive failure[6, 9] although the role of hormones (such as aldoste-

rone) also is important (secondary hyperaldosteronism).

To alter this pathophysiologic state, a number of diuretic agents have been synthesized and employed. Of these, the injectable organomercurials remain in general the most effective, best tolerated and least expensive. A single intramuscular injection usually produces a maximal increase in urine flow within six hours. These drugs are nearly always effective at first in the untreated patient, but they have some disadvantages when used repeatedly. In the case of a patient with moderately severe or advanced congestive heart failure on a regimen of rigid salt restriction, frequent injections may produce hypochloremic alkalosis, hypokalemia, and failure to respond to continued administration of these drugs. If the true nature of the condition is not recognized, the physician may erroneously conclude that the patient is in a state of intractable failure. Indeed, in the past, this was a fairly common diagnostic error.

Rubin and associates[10] published a report of their observations after a study of patients who appeared to have refractory edema, that is, edema that did not respond to routine management with rest, digitalis, salt restriction and mercurial diuretics. By inducing hyperchloremic acidosis through the use of ammonium chloride and acetazolamide, they restored the diuretic response to mercurials. This regimen has been found to be effective both for patients with normal electrolyte patterns and for those with chloride depletion. Briefly, 8 to 10 Gm. of ammonium chloride is given daily in divided doses for three or four days. Acetazolamide 250 mg. twice a day is given for the first two days. A mercurial diuretic is then given on the fourth day. (For reasons that are not clear, acetazolamide given immediately preceding the administration of a mercurial is likely to decrease the diuretic effect). Ammonium chloride may not always be acceptable to use. Even when given in enteric coated tablets, it may cause nausea and vomiting and frequently the pills are passed out intact in the stool. Moreover, patients who need the drug most, that is, those in severe congestive heart failure, are most susceptible to its toxic effects. In some of these cases, the administration of ammonium chloride creates the hazard of precipitating ammonia toxicity because of the decreased ability of their large, congested livers to metabolize the ammonia.

When the use of ammonium chloride seems inadvisable, either lysine[11] or arginine monohydrochloride[7] may be given for the same purpose. Both have been found to be beneficial when given in divided doses totaling 40 Gm. daily, administered either orally or intravenously. Lysine and arginine have no diuretic action and serve mainly as vehicles for carrying the choride ion. These compounds cause little, if any, gastrointestinal disturbance and are well absorbed from the gastrointestinal tract when taken orally. The only difficulty that might be encountered would be the objection of some patients to their rather peculiar taste.

Aminophylline, a weak diuretic in its own right, can be used to augment the effect of the mercurials. The mercurial diuretic, along with 0.5 to 1 Gm. of aminophylline, should be given intravenously in 100 to 200 cc's. of 5 per cent glucose in water over a period of 20 minutes. Although the aminophylline is best given concurrently, it will enhance diuresis if given within three hours after the mercurial, by infusion as described above. Its action increases the glomerular filtration rate and renal plasma flow. Thus, a greater quantity of sodium and chloride is presented to the proximal tubule and excreted, since reabsorption of these ions is blocked by the mercurial.[12]

The standard schedule for administration of mercurial diuretics is an injection every two to four days, but some patients may require more frequent injections. Ordinarily an effective diuresis is obtained within the first 24 hours after injection. Occasionally, however, weight gain that sometimes equals or exceeds the weight previously lost through diuresis may follow within the second 24 hours. The physician may then erroneously conclude that the patient is in a refractory state of failure. Antidiuresis sometimes may follow diuresis after the administration of a diuretic agent. When this occurs, the diuretic response predominates during the first 12 to 24 hours, but thereafter the antidiuretic response may overcompensate the effect of the diuresis. The problem of excessive antidiuretic response can be overcome by more frequent administration of the diuretic when necessary. (The physiologic mechanism that results in antidiuresis is not well understood. Excess secretion of antidiuretic hormone by the posterior pituitary, excess secretion of an adrenal steroid, and activation of osmoreceptors are among possible intermediate causes for this phenomenon that may be triggered by the diuresis).

Although corticosteriod hormones are notorious for causing retention of sodium and water, glucocorticoids have been found useful on occasion for some patients with congestive heart failure

when given in proper dosage as a supplement to the mercurial diuretics.[13-17] Nevertheless, it has been our experience that the value of steroids for this purpose is extremely limited, and that the therapeutic response is extremely difficult to evaluate. The rationale for their use is that glucocorticoids (a) increase glomerular filtration rate, (b) inhibit the secretion of antidiuretic hormone, (c) suppress secondary hyperaldosteronism, (d) repotentiate diuretic drugs and (e) have an anti-inflammatory action which is useful in such conditions as rheumatic heart disease.

Standard dosage schedules have not been established. The dose level at which either the sodium retaining or the sodium excreting effect of a given glucocorticoid will predominate appears to be critical and must be found empirically in each case.

Newman[14] suggests the following regimen: Continue the standard measures of rest, salt restriction and digitalis. Start prednisone in daily doses of 2.5 mg., then increase by 2.5 mg. every three or four days to a maximum of 15 to 20 mg. daily. After the maximal dose has been given for four or five days, an injection of mercurial diuretic is given. The amount of prednisone should then be decreased gradually over an interval of time that is determined by the patient's response to the mercurial, which is given concurrently with the prednisone after the initial course of priming with the steroid alone. Newman found the average maintenance dose of prednisone to be 5 mg. daily.

The diuretic response to glucocorticoids alone is somewhat unpredictable. There usually is a moderate weight gain in the first three to four days, followed by diuresis after the fifth or sixth day of administration. The most gratifying result of using glucocorticoids in this manner is the return of response to diuretics. Because the response is so uncertain, however, we have been led to abandon this therapeutic approach except in the most unusual circumstances.

The orally administered thiazide diuretics are convenient for long term maintenance of patients with chronic congestive heart failure, but are not very useful in the emergency situation. Their effect is maximal two to four hours after administration, and slowly wanes within 12 to 18 hours.[18] Even in amounts producing maximal response, however, a single dose is not as effective as an injection of one of the mercurial diuretics. Patients who are taking any of the thiazides must be watched carefully for signs of digitalis toxicity because these drugs have a considerable kaluretic effect.

As an adjunct to the principally used diuretics, the antialdosterone agents spironolactone and triamterene may be helpful in several ways. Primarily, they help to counteract the secondary hyperaldosteronism that often is present in chronic congestive heart failure.[7, 19] In addition, both of these agents favor the retention of potassium while promoting the urinary excretion of sodium, thus obviating the need for potassium supplements when used in conjunction with a thiazide diuretic.[7, 20-22] Spironolactone, which is a weak diuretic when used alone, has been found valuable in augmenting the effect of the mercurials and the thiazides.[7] Triamterene, a new diuretic agent chemically unrelated to other currently available diuretics, is believed to promote sodium excretion by exerting a direct effect on the distal renal tubule[20-24] as well as by its anti-aldosterone effect.[19-25] It is reported to be effective in the treatment of edema that is refractory to mercurial or thiazide diuretics or to combinations of these.[26] A combination of triamterene and a thiazide seems to be ideal for achieving effective natriuresis without excessive loss of potassium.[20-23]

Preliminary reports on a new diuretic, ethacrynic acid, reveal it to be an extremely potent natriuretic agent.[27-29] Maher and Schreiner[29] found it to be remarkably effective in patients with edema that had proved refractory to treatment with mercurial and thiazide diuretics despite the supplemental use of spironolactone, mannitol and acidifying agents. Ethacrynic acid was also effective in patients with hyponatremia or hypochloremic alkalosis. The potency of this new drug dictates the need for very close monitoring of electrolytes in patients to whom it is given. Failure to observe this precaution can result in serious problems of electrolyte imbalance and expose the patient to the hazards attendant upon such imbalance through indiscriminate use of the drug.

Special Therapeutic Techniques
Methods for Alleviating Fluid Retention That Is Refractory to Standard Treatment

Fasting.—Bloom[30] found that hospitalized patients who were treated for obesity by total fasting, with free access to water, lost more weight than could be accounted for by caloric energy expenditure or expected urinary water loss. In a later study, he found that fasting patients excrete sodium in significantly greater amounts than patients on a low salt diet.[31]

With this principle in mind (i. e., natriuresis induced by fasting), Merrill[32] placed on a fasting regimen two patients in severe refractory heart failure that had become unresponsive to full

digitalization, stringent salt restriction and intensive diuretic therapy. He reported that five to seven days of fasting produced satisfactory diuresis, resulting in substantial weight loss and return of cardiac compensation at rest.

Dialysis.—This procedure has been found helpful in reducing the extracellular fluid volume in patients with rheumatic heart disease and refactory congestive failure who are being prepared for operation. Either peritoneal dialysis or hemodialysis, using hypertonic dialyzing fluids, may be employed for this purpose. Occasionally, patients in refractory failure caused by other forms of heart disease may experience spontaneous diuresis after part of the fluid overload has been removed by dialysis.[33]

A simplified modification of the artificial kidney, which is known as extracorporeal ultrafiltration, has been used successfully by Anthone[34] to prepare patients with refractory edema for surgical procedures, and also to provide comfort to patients in the terminal phases of cardiovascular-renal disease.[34]

Mechanical Removal of Fluid.—The mechanical removal of edema fluid or transudate from patients with hydrothorax or ascites not only ameliorates the subjective complaint of discomfort but also has been known to restore the response of patients with refractory edema to routine management. Levin and Klein[35] reported that some patients in whose cases repeated thoracenteses were performed again became responsive to mercurial diuretics. They liken the repeated removal of large quantities of intrathoracic fluid to a sump phenomenon. In a similar manner, response to diuretic therapy has been restored after relief of massive leg edema by means of Southey tubes.[36] Multiple punctures for the withdrawal of fluid with a regular hypodermic needle also might produce good results. Asepsis is most important in these procedures, and antibiotics should be administered prophylactically to combat the possibility of infection.

The use of tourniquets [37-39] and phlebotomy[40] will decrease pulmonary venous pressure and improve compliance, thereby improving ventilation.

Induced Hypothyroidism.—In euthyroid patients, refractory congestive heart failure sometimes may be ameliorated by the induction of a hypothyroid state with I^{131}. The effectiveness of this procedure as determined by general improvement in the patient's condition varies betwen 60 and 80 per cent, according to different reports.[41, 42] The effects of mild hypothyroidism may be beneficial in several ways: (1) With the over-all reduction in metabolic processes, cardiac work is reduced, (2) adrenergic stimulation of the cardiovascular system may be reduced, (3) pain perception may be decreased and (4) intercoronary collaterals may develop at an increased rate.

Refractory Failure Due to Complicating Diseases

It has been stated earlier in this discussion that evaluation of the patient who is in refractory congestive failure must include a diligent search for possible complicating factors and diseases. The correction of such conditions often may either cure the heart failure completely or at least allow the myocardium to respond to therapy. This point cannot be too strongly emphasized. In the section that follows, we shall discuss some conditions that have been found to cause congestive heart failure, or to make it more refractory to usual methods of treatment. Specific therapeutic measures will be described briefly, together with suggestions for their use.

Primary Pulmonary Disease.—In a study of 44 fatal cases of intractable congestive heart failure reported by Nuetzel,[43] autopsy frequently revealed complicating factors which had not been diagnosed ante mortem. The most common of these were pulmonary emboli and bronchopneumonia. Major pulmonary emboli were found in 38 per cent of the cases, and bronchopneumonia in 31.5 per cent.

The pulmonary emboli were not considered the initiating cause of the failure in most instances; they appeared, rather, to be a complicating and aggravating factor. The high incidence of pulmonary emboli in congestive heart failure presumably is related to pulmonary congestion.[44] The textbook symptoms of pleuritic chest pain, hemoptysis and dyspnea, or the wedge-shaped density seen on x-ray, are not as common as might be expected. Therefore, if multiple pulmonary emboli are suspected, it would seem advisable to institute anticoagulant therapy when congestive heart failure does not respond adequately to standard methods of treatment.

Bronchopneumonia frequently is overlooked, especially in the elderly patient.[45] A high index of suspicion is needed, and necessary diagnostic and therapeutic measures should not be omitted simply because the patient has few complaints. Broad antibiotic coverage appears to be justified for desperately ill patients in terminal congestive heart failure, although Nuetzel[43] reports that he found no evidence of beneficial effect after

patients in his series were given ordinary doses of antibiotics. He suggests the use of massive dosage to help overcome the adverse and therapy-negating effects of severe pulmonary congestion and hypostatic factors.

Disturbances in Heart Rate.—The control of arrhythmias also is of great importance. The work of the heart is increased by a rapid heart rate, which is most costly in terms of cardiac reserve. Because of the short diastolic rest period, coronary blood flow is decreased. Rapid regular or irregular tachycardia or frequent premature contractions, especially those of ventricular origin, will seriously reduce the cardiac output and blood pressure as well as the coronary blood flow. Prompt use of anti-arrhythmic drugs, such as digitalis, quinidine or procainamide is essential. If the blood pressure is critically low, one of the sympathomimetic amines may be given.[46]

Complete atrioventricular block, resulting in slow ventricular rates, is not infrequently associated with intractable congestive heart failure on the basis of deficient cardiac output. Treatment of the heart failure often is of little efficacy so long as the underlying defect remains uncorrected. Patients in whose cases electrical pacemakers are used in these circumstances often show great improvement and respond quickly to routine management when the normal heart rate has been restored.[47]

Hypertension.—When the patient is found to have hypertension, a search should be made for potentially reversible causes such as renal, renovascular or endocrine disorders. If thorough investigation reveals no apparent cause, the physician must proceed on the assumption that the patient has essential hypertension and undertake to lower the blood pressure by direct means. This can be done effectively in most cases by administering one of the many antihypertensive agents currently available, or a combination of these. As the blood pressure decreases, cardiac compensation usually is achieved.

At one time nearly one-third of all patients with severe diastolic hypertension died of congestive heart failure. Today, with effective antihypertensive therapy, congestive heart failure as a primary cause of death among these patients is unusual.

Constrictive Pericarditis and Clinically Similar Conditions.—Chronic constrictive pericarditis can persist for many years, eventually causing chronic congestive heart failure. In elderly patients it often is overlooked as a possible cause of heart failure which may appear to be due to a previously diagnosed condition such as hypertensive or coronary atherosclerotic heart disease. It should be remembered that the classic findings of a small, quiet heart, venous distention, and distant heart sounds are not essential for a diagnosis of constrictive pericarditis. In patients with previous cardiac hypertrophy or associated pericardial effusion, the heart may show considerable enlargement on x-ray and physical examination; the constricting band may involve only a small segment of the heart surface.[13] Cardioangiography or even thoracotomy may be necessary to elucidate this problem. The presence of pericardial effusion or tamponade is best determined by pericardiocentesis if findings include a narrow pulse pressure, bottle-shaped heart with obliquely blunted cardiophrenic angles, and markedly elevated venous pressure.

Several other conditions can mimic constrictive pericarditis. Among these are amyloidosis, endocardial fibroelastosis and hemochromatosis.[48] Hepatic cirrhosis may also be difficult at times to distinguish from constrictive pericarditis.

In elderly patients, senile amyloidosis of the heart is a fairly common finding[49, 50] but usually is not extensive enough to cause cardiac decompensation.[51] Primary amyloidosis involves the heart in about 80 per cent of the cases studied at autopsy; half of these show involvement of sufficient extent to have been a probable cause of congestive heart failure. There are several types of cardiac lesion due to amyloidosis that may lead to heart failure. For example, there may be (1) diffuse or nodular myocardial deposits, (2) the visceral pericardium or endocardium may be infiltrated and (3) one or more valves of the heart may be affected by the process. Various combinations of such lesions occur, presenting a complex clinical picture. In some cases, amyloidosis of the heart may closely mimic constrictive pericarditis by restricting myocardial contraction and relaxation.[48] Diagnosis, like that in other rare or atypical diseases, is largely a matter of keeping the possibility in mind—in this instance, the possibility of systemic amyloidosis involving other tissues of mesodermal origin as indicated by attendant symptomatology.

Endocardial fibroelastosis occurring in adults or adolescents usually is acquired. This condition may be due, in part, to the organization of plaque-like thrombi attached to the endocardial surface. Irregular projections of fibrous and elastic tissue may extend from the thickened endocardium into the adjacent myocardium, causing myocardial fibrosis. The left ventricle usually is affected to a greater extent than the right, and

the atrioventricular valves may be affected as well, so that valvular insufficiency occurs. Again, clinically, this condition may resemble constrictive pericarditis.[48] For this condition, however, as for amyloidosis, there is no specific therapy other than for relief of symptoms.

In hemochromatosis, the onset of cardiac decompensation usually is insidious, without any indication of previous cardiac disease. The clinical features are those of congestive heart failure and are not otherwise unusual. The cardiac failure generally is attributed to impairment of myocardial cellular metabolism due to overload with iron pigment rather than to secondary myocardial fibrosis. In this condition the congestive heart failure responds only partially to conventional forms of treatment as a rule, but may show great improvement after serial phlebotomies have been carried out to near anemic levels.[48] Here, the characteristic "bronze diabetes," with hepatic cirrhosis and a high serum iron, offers a clue to the diagnosis.

Nonrheumatic Myocarditis.—The incidence of myocarditis from all causes and in all degrees of severity is fairly common, but myocarditis severe enough to cause overt congestive heart failure is less common than the usual forms of heart disease that lead to congestive failure, i. e., atherosclerotic, rheumatic, hypertensive or leutic heart disease.[52] It may occur as a secondary result of various types of infection or of the effects of toxic agents, or a part of a hypersensitivity reaction.

Myocarditis occurring as a primary myocardial disease is suggested by the following symptoms and signs:

(1) Onset with biventricular failure.

(2) Failure of the myocardium and its specialized tissue to initiate and conduct the heart beat in normal manner, as evidenced by disorders of conduction and the development of arrhythmias.

(3) Gross cardiomegaly due to generalized enlargement of all chambers, as contrasted with dilatation and hypertrophy of a single chamber or combination of chambers indicative of some form of chronic heart disease.

(4) A murmur that is of maximal intensity at the height of failure and cardiomegaly (because of the incompetence of the atrioventricular valves) and is minimal or absent when the patient is out of failure (because dilatation of the valve ring is decreased or absent when the heart is smaller in size). This is in contrast to the murmur found in patients with organic valvular disease and heart failure, which is of greater intensity when the patient is out of failure.

(5) Ventricular gallop. This often is the earliest sign of failure in myocarditis. It is not as frequent a finding in failure due to congenital heart disease or the acquired valvular disease.[52]

Infection of various types is among the more common causes of secondary myocarditis. It can be caused by the diphtheric exotoxin and is found also occasionally as a complication of some viral diseases. These include poliomyelitis, influenza and Coxsackie virus infections. In the young military population, Coxsackie B virus is a fairly prevalent cause of myocarditis.[53]

Certain parasitic diseases, for example schistosomiasis,[54] toxoplasmosis,[53] and Chagas' disease,[53] have been known to cause diffuse chronic myocarditis, with intractable heart failure as the end result.

Emetine,[55] butazolidin and sulfonamide[53] therapy have been implicated as infrequent causes of congestive heart failure due to myocarditis.

Specific treatment is determined by the underlying cause of the myocarditis.

Trauma.—Traumatic injury of the heart that is extensive enough to cause intractable failure is rare. When it does occur, it most often is the result of injury caused by penetrating lesions, and the circulatory failure is a consequence of acute tamponade.[55] Burchell[55] reports a case of traumatic rupture of the ventricular septum caused by nonpenetrating trauma in a patient who presented with acute heart failure. After surgical repair, the heart returned to a state of normal function and the patient did well.

Neoplasm.—Cardiac neoplasms may at times first manifest their presence enigmatically as intractable heart failure. This is especially true of atrial tumors, whether primary or metastatic. Myxomas of the left atrium are well known to mimic mitral stenosis clinically.[56, 57] In patients with these tumors, however, unlike those with rheumatic mitral stenosis, variations in posture usually produce rapid and striking changes in clinical status as the mass engages or frees itself from the orifice of the valve. The results of cardiac catheterization may suggest mitral stenosis, but angiocardiography will reveal the intra-atrial mass.[56] Surgical removal of the tumor completely relieves the symptoms. Metastatic tumors,

especially those arising in the kidney, may secondarily invade the right atrium through the inferior vena cava. In this location a primary or a metastatic tumor not infrequently becomes apparent as right inflow stasis.

Primary rhabdomyosarcomas of the heart are rare, and secondary tumors of the myocardium, even though they are extensive in some instances, seldom cause heart failure.[55]

Primary and secondary tumors involving the pericardium give rise to the signs of chronic congestive heart failure as well as of acute tamponade.[55] Pericardial mesotheliomas may present the picture of pericardial effusion with mild fever and recurring arthralgias, simulating rheumatic fever.[55]

Summary

The successful treatment of congestive heart failure depends to a great extent on thorough understanding of the biochemical and physiologic factors involved in the maintenance of cardiac output. Proper diagnosis of the underlying cause is equally important as a prerequisite for planning therapy that will be most effective for the individual patient. Correction of conditions that may be causing the heart failure should be attempted whenever possible, either concurrently with routine treatment or instead of such treatment.

Standard therapeutic measures employed in treating all but the exceptional patient consist of rest, salt restriction, digitalis and diuretic therapy. It is in the use of digitalis and of the various diuretics that an understanding of the physiologic principles which govern the pharmacologic action of these drugs can be of greatest value. A major hazard is the production of electrolyte abnormalities through injudicious or prolonged use of diuretics, but this can be avoided by careful monitoring and administration of electrolyte supplements if necessary. Some adjuncts to diuretic therapy that are helpful occasionally are aminophylline, certain chloride compounds and, on occasion, even corticosteriod hormones such as prednisone. Aldosterone antagonists are particularly valuable for use in conjunction with mercurial or thiazide diuretics because of the tendency for secondary hyperaldosteronism to develop in congestive heart failure.

More unusual methods of treatment may be employed at times when ordinary measures are not effective. Removal of edema fluid may be accomplished by dialysis or by actual drainage in extreme cases. Phlebotomy and tourniquets may be used to decrease the cardiac work load temporarily. Fasting has been used successfully to produce diuresis in a few patients with refractory edema. Restoration of normal rhythm by means of an electrical pacemaker in a heart with a rapid arrhythmia often results in gratifying improvement in the patient's condition, as does the reduction of blood pressure in patients with heart failure due to hypertension. In these cases cardiac output is increased after the abnormal condition is corrected, and the patient responds well to routine treatment thereafter. Induced hypothyroidism has been found helpful for some patients, primarily because the decreased metabolic requirements lessen the cardiac work load.

Some correctable causes of congestive heart failure, or aggravating factors, are pulmonary embolism, bronchopneumonia, pericarditis and tumors of the heart. The presence of any of these conditions dictates to some extent the therapeutic program to be followed.

The treatment of congestive heart failure due to myocarditis depends largely on the cause of the myocarditis, which is basic to the problem. Some conditions, for example, amyloidosis and endocardial fibroelastosis, are not at present correctable, so that only supportive therapy can be provided.

A list of references may be obtained by writing to The Journal.

He is a good man who can receive a gift well.

RALPH WALDO EMERSON.

Fibromata of the Testicular Tunicae

Robert A. McDougal, M. D., David B. Thornburgh, M. D., and Paul L. McCuskey, M. D.

Tumors in the scrotal sac of a young man are cause for immediate investigation. Tumors of the testis are those which cause most alarm, since many of these are malignant.[1] Tumors of the testicular tunicae are less common but must be considered. Only about 50 such tumors have been reported, most of which were benign.[2] The most common is the fibroma, which may be solitary or multiple.

Hinman and Gibson,[3] in 1924, in a review of tumors of the epididymis, spermatic cord and testicular tunicae found 13 acceptable cases, including the earliest, reported in 1858. Lewis and Pierce,[4] in 1962, reported 2 new cases of multiple fibroma which they added to 17 others they had located in the literature. Orlay[5] had reported a similar case in 1961, not included in those mentioned by Lewis and Pierce.

Case Report

The patient was a 21-year-old white man. He was found to have extensive, nodular hardening of the left scrotal contents. This was thought to represent thickening of portions of the left testis and cord, and to represent a probable malignant tumor. Immediate orchiectomy was advised. There was no pain nor tenderness of the scrotal mass. The remainder of the physical examination was normal. A fasting blood sugar, urea nitrogen, complete blood count and urinalysis were normal, while the V.D.R.L. and a test for gonadotropins (Gravindex, Ortho) were negative.

At surgery the left tunicae with testis and attached cord were removed. The cord was 7 x 2 cm., the tunica 8 x 6 x 4 cm. The testis was 4 x 3 x 3 cm. Attached to the inner wall of the tunica were numerous firm, gray lobular masses, some conglomerate, measuring from 0.5 to 4 cm. in diameter. The testis and cord were not involved, and microscopically were normal except for edema and reduced spermatogenesis. The tumor consisted of whorls of dense connective tissue containing mature fibrocytes. Focal chronic inflammation was present. A trichrome stain confirmed that most of the stroma consisted of collagen, although a fair amount of vascular smooth muscular tissue was evident.

Submitted to the Publication Committee, June 16, 1965.

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The patient made an uneventful recovery and has remained asymptomatic.

Comment

These tumors have been considered as benign neoplasms (fibromata) and as chronic vaginalitis (chronic proliferative periorchitis).[6] Dixon and Moore refer to fibromata of the cord and tunicae.[1] The possibility of such tumors should be kept in mind when a firm, painless, nodular tumor is palpated in a young man's scrotum. In some cases the testis can be saved,[5] although because

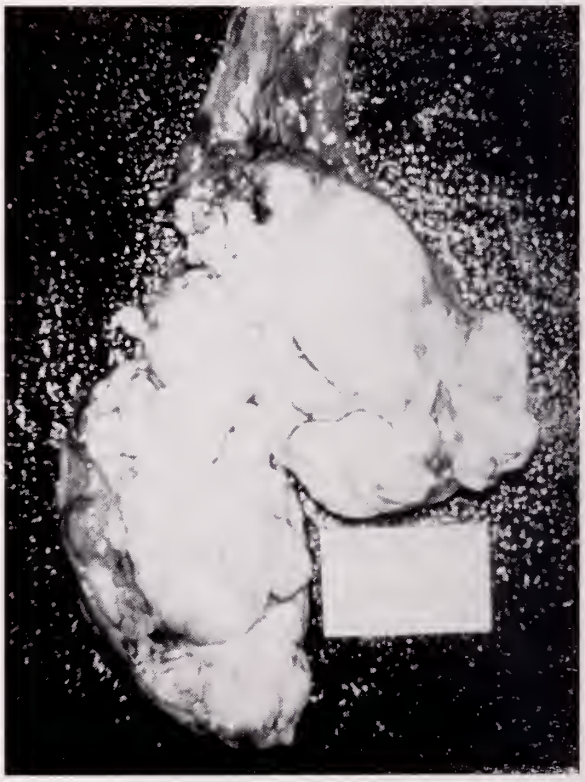

Figure 1. Testis (upper right) and opened tunica showing nodular fibromata.

of the fear of disturbing a highly malignant testicular tumor, castration usually is performed.

Summary

A case of fibromata of the testicular tunicae is reported. The condition must be included in the differential diagnosis of painless, firm scrotal tumors.

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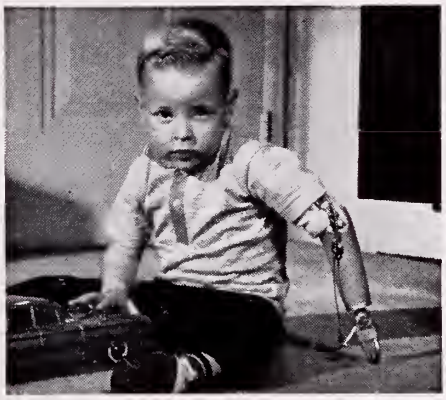

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Complete blood cell counts should be made before and after therapy, especially if a second course is necessary.

Infrequent and minor side effects include: nausea, unpleasant taste, furry tongue, headache, darkened urine, diarrhea, dizziness, dryness of mouth or vagina, skin rash, dysuria, depression, insomnia, edema. Elimination of trichomonads may aggravate moniliasis.

Dosage Forms

Oral—250-mg.tablets/Vaginal—500-mg.inserts

SEARLE

Research in the Service of Medicine

The President's Page

REBIRTH OF COURAGE

In this most sacred season of Christmas time when animosities are lost in the joy of the birth of our Saviour Jesus Christ, let us all join together in rejoicing in the happiness and health that exists in the world, and work for that day when more of our fellowmen may share in these blessings.

May I on behalf of the officers and the official family at headquarters express the wish that your Christmas was a very happy one and that you and your families can look forward confidently to the New Year with its many challenges and its opportunities.

With the myriad of problems involved in the implementation of the Medicare Program, we must have the courage to innovate and accept new approaches to achieve an equitable solution of providing the highest quality of medical care without more sacrifices of our principles. We no longer can be afforded the luxury of procrastination or supposition. It is self-evident that on many occasions less time and effort would be lost if we sat down and adopted a workable approach rather than waiting for the coming of a latter-day solution from some nebulous expert in Washington or Chicago.

It certainly appears that this implementation will be another "Do It Yourself" project, and many committees of your State Medical Association are already at work formulating guide lines and framework decisions to assist and clarify the course which we should follow. These meetings will be reported in *The Journal* and by special communication as they develop.

Let us have the courage to accept new ideas. Let us have the strength of our convictions and our abilities to work out an equitable solution to our problems. But let us get on with our responsibilities.

Seigle W. Parks, M. D., President

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EDITORIALS

POLITICAL OBSTETRICS ON THE POTOMAC

When this issue of *The Journal* comes to hand many of you subscribers will be in the first throes of compiling the statistical material required in filing your 1965 tax returns. As you scan the past year for deductions and exemptions it might be informative, although not necessarily pleasant, to take a refresher course in political obstetrics as practiced by the accoucheurs on the Potomac.

The year 1965 will henceforth be identified as a twelvemonth in which the Great Society really came into being, activated by a spate of internal and external pressures, and hailed by its progenitors as an unguent which will heal the social and economic cankers and sores of all deserving American citizens.

It has been alleged that one of these siblings, with a given name of Medicare, was sired under the sheets of political expediency, nurtured and reproduced by a spineless and rubber-stamp Congress, and delivered into the waiting hands of bureaucrats and politicians for post-natal nurture and development. The progenitors of this catch-all infant did accept the benefit of a short fifteen minute consultation during the period of labor, but paid no heed to the advice offered.

Well, the infant, with all its blemishes, is on the scene, and we are confronted with a fait accompli. It cannot be re-inserted into the congressional reproductive tract, and even though somewhat unloved we must assume the responsibility of doing all within the realm of constructive criticism and group co-operative action and expression to the end that this legislative infant will develop in stature and character for the good of all who need and deserve the benefits of foster parentage.

Already, many of our leaders and members are giving their time and talents in the promulgation of rules and regulations required for the operation of this costly experiment in social and economic welfare. As individuals, many of us have the right and will assume the responsibility of non-participation in this socialistic experiment. That is a matter for individual conscience and decision. Organized medicine will accept the status quo, and will make a fair and honest effort to correct any inequities now present to the end that all hands will receive what they need and what they deserve.

Next month,—not East Lynn, but a few thoughts concerning the miracle which must be accomplished within months if misunderstanding and chaos is to be avoided because of the lack of facilities to meet the expected demands of some 20 million older citizens.

Selah.

A REPORT TO THE MEMBERSHIP

The Clinical Session of the House of Delegates of the American Medical Association met on Sunday afternoon, November 28, 1965, and concluded its work on Wednesday afternoon, December 1. *The Journal* will publish a formal statement of the actions of this body but it appeared that some personal impressions of the meeting might be of interest to our members.

The day prior to the opening of the meeting a very active session, devoted to the Utilization and Review Committees, was attended by approximately 800 physicians and others. It should be pointed out that this will be a vital part of the implementation of Public Law 89-97. Hospital staffs which do not have an active Utilization Committee should take immediate steps to develop such committees. It is understandable that there is still some confusion in the Understanding of Utilization and Review, but once the regulations are published by the Department of Health, Education and Welfare, it will probably be much simpler to develop a working committee for this purpose.

Your Delegates noted that for the first time in many years a regular called session of the House of Delegates did not have resolutions introduced relative to Social Security coverage for physicians. The resolutions and supplementary reports were referred to Reference Committees, which began their hearings on Monday afternoon. Although there were not, numerically, the usual number of resolutions presented, several of the resolutions stimulated active discussions.

On Wednesday morning the Reference Committees made their reports, and their actions were voted upon by the House. Many of them passed without any particular opposition. The great majority of resolutions, such as making a special calling of the House more difficult and the one requiring a member of the Board of Trustees who seeks the office of President Elect to be off the Board for one year, were defeated without opposition. Heated discussion followed the Reference Committee's report upholding the resolution that the Committee on Constitution and By-Laws be authorized to draft the necessary amendment to permit a $25 yearly increase in dues. The Reference Committee's action was upheld by a close vote. There also was exhaustive discussion regarding the AMA sponsorship of abortion for certain specified reasons. The Reference Committee deferred any action on this subject and the House of Delegates upheld its action.

Since there were twelve reference committees in session at one time, it is obvious that your two Delegates could attend only a small percentage of them.

One point which was of great interest in connection with the Medicare Program was the recognition of the prevailing fee concept as A method for reimbursement of physicians. A small verbose group insisted on the plan of "usual and customary fees." It was pointed out that the Board of Trustees and the Council on Medical Service had not stated that either was the ideal method of reimbursement, but that the prevailing fee concept was one method of reimbursement which was acceptable.

As defined: "Usual" is that fee usually charged, for a given service, by an individual physician to his private patient (i.e. his own usual fee).

"Customary"—a fee when it is within range of usual fees charged by physician of similar training and experience, for the same service within the same specific and limited geographical area (socio-economic area of a metropolitan area or socio-economic area of a county).

"Reasonable"—when it meets the above two criteria, or in the opinion of the responsible medical association's Review Committee, it is justifiable, considering the special circumstances of the particular case in question.

Opponents of any type of fee concept pointed out the possibility that we would be obligated to hold to a fee schedule in the future. Proponents of the prevailing fee concept insisted that this was not a fee schedule and was in actuality the usual and customary fee.

One of the most interesting sessions of the entire meeting was a meeting of the Advisory Committee of the AMA with the Department of Health, Education and Welfare and the physician-members of the six Task Force Committees, who were appointed by Secretary Gardner to give advice on implementing the Medicare law. This meeting went on for three hours and could have lasted for many more. Briefly each speaker expressed the opinion that the Committees were treated courteously and given ample opportunity to express their opinions before the Administration's representatives, but at the conclusion of the meetings, the committee members had no knowledge as to what the regulations on the law would reveal. There was obviously a strong current of fear, from the expressions by the physicians present, that re-

gardless of whatever the regulations would state when issued, that as time went on, amendments would unquestionably be added and that more and more of the physician's practice, particularly in the hospitals, would be under federal control.

Frank J. Holroyd, M. D.
C. A. Hoffman, M. D.
Delegates

THE POP TAX

The legislative season soon will be with us and according to custom the medical profession should be concerned about the annual effort to annul the Pop Tax. After 10 years it does seem that everything pro and con has been declared in this controversy.

The taxpayers who are engaged in the practice of medicine believe the Pop Tax is a harmless, painless and proper tax on a luxury item; that the tax money is being expended in the support of our greatest educational venture since inauguration; that in this decade when West Virginia has been subjected to ridicule and scorn from without, we can in exultation point to the West Virginia University Medical Center and pridefully hold our own with any other state, city or private medical school in the United States.

If you think this Center should be abolished or inhibited, then discontinue the tax. If you are aware of the dire need for physicians and highly classified medical service, then stop placing the Medical School in annual jeopardy. The regular assault on this tax by selfish interests is a threat not only to the active existence of the school, but alternate methods of financing would endanger the present attractive position of this Center among the healing and teaching institutes of the land, and add disillusionment to the program and planning that can bring better medicine to all of West Virginia.

Pop is a luxury item. It adds nothing to the growth and nutrition of the human body. Madison Avenue has dunned our ears with flowery phrases that have become well-known slogans, but to many people pop represents only a burp, a belch and a bellyache. Like alcohol and tobacco, pop should provide some extra revenue for our state treasury. Many of us have hoped that the bottlers might some day carry a full page advertisement of our Medical Center with a flying pennant "See What Pop Has Done For West Virginia." That will be the day!

Now is the time for all of us again to rally to the support of West Virginia's outstanding Medical Center. All you old grads, young lads, foreigners and interlopers unite to protect and to polish what we have and what we propose to keep. So Call and Write, singly and jointly, the Governor, the Members of the Board of Public Works, Senators and Delegates stating your support of the Pop Tax. Secure a firm conviction now before your lawmakers are exposed to the jiggery pokery of the bottle lobbyists.

EVOLUTION OR REVOLUTION?

In a release from the Association of American Physicians and Surgeons dated November 15, 1965, it was estimated that more than 50,000 doctors had already made a firm decision not to participate in Medicare. That figures out to about 25 per cent of physicians who have examined their hearts and consciences as regards the ethical relationships between patient, doctor and government embodied in Public Law 89-97 and who reportedly will not collaborate in the implementation of the law as it now stands.

Three weeks later, in a press release dated December 7, 1965, Dr. Edward Annis, who might well be considered as one of the spokesmen for organized medicine, stated that 90 per cent of the physicians would refuse to participate in a health care program in which it is alleged that the federal government will interpose its authority and influence between doctor and patient.

Without regard for the reported increase from 25 to 90 per cent of non-collaboration in the span of three weeks and the political and economic connotations contained therein, this observer is impressed with the definite probability of the chaos which will eventuate when the Medicare program, sired by political expediency and conceived in an unholy tripartite wedlock between socialistic labor leaders, power-seeking bureaucrats and vote-hungry politicians, makes its debut next July.

These almost certainties must accentuate our determination and govern our actions to the end that our worthy and deserving indigents receive adequate health care under a tax system which will encompass all citizens in an equitable fiscal arrangement. The acts of a rubberstamp Congress can never give an air of legitimacy or justice to a program so badly planned.

We must never forget that Public Law 89-97 is but a foot in the door which opens to complete socialism.

GENERAL NEWS

Annual AMA Clinical Convention Held in Philadelphia

A large number of West Virginia physicians attended the 19th Annual Clinical Convention of the American Medical Association in Philadelphia, November 28-December 1.

Drs. C. A. Hoffman of Huntington and Frank J. Holroyd of Princeton, AMA Delegates from West Virginia, were in attendance at all sessions of the House of Delegates during the four-day meeting.

Also attending the meeting in Philadelphia were Dr. Seigle W. Parks, of Charleston, President of the State Medical Association; Dr. Richard E. Flood of Weirton, the President Elect; Dr. A. C. Esposito of Huntington, Chairman of the Council; Dr. Richard W. Corbitt of Parkersburg, a member of the Council; and Dr. L. J. Pace of Princeton, a Past President.

Summary of Philadelphia Meeting

The following summary of the Philadelphia meeting was prepared for publication by Dr. F. J. L. Blasingame, Executive Vice President of the American Medical Association.

"Usual and customary" fees and prevailing fees, abortion and sterilization, billing and payment for medical services, membership dues, organization of the House of Delegates, and federal health care laws were among the major subjects acted upon by the House of Delegates during the Clinical Convention.

Dr. James Z. Appel, the President, in his address to the House on Sunday described medicine's efforts "to guide in the best possible direction the actions that government agencies are now taking to activate existing law (PL 89-97)." He then reviewed the activities and responsibilities of the six technical advisory committees under the Medicare law.

"Their suggestions have been received favorably in most instances," he said. "And we are hopeful that they will be translated into the final published regulations . . . (but) we know that in certain significant instances this will not be true."

'Usual and Customary' and Prevailing Fees

One of the most controversial issues before the House and the Reference Committee on Insurance and Medical Service was the "usual and customary" fee concept and the prevailing fees program of the National Association of Blue Shield Plans.

The House reaffirmed its support of the "usual and customary" fee concept as the basis for reimbursing physician participants in government programs at all levels of government. It also urged "the individual physician's usual and customary fee concept to all third parties."

It took this action after modifying a Board of Trustees' report on the new "prevailing fees" program of NABSP. The modified report recommended:

"That the concept of the prevailing fees program of the NABSP be noted as one of the methods of compensation in those regions where the prevailing fees program is approved by the local or state medical society."

In its report, the Board recalled a statement adopted by the House at the 1965 Annual Convention, which recommended that when government assumes financial responsibility for an individual's health care, reimbursement for professional services should be on the same basis as in the case of other indispensable elements of health care.

"Therefore, reimbursement for the services of physicians participating in government-supported programs should be on the basis of 'usual and customary' fees," the statement said.

Abortion and Sterilization

Recommendations for the enactment of legislation to legalize abortion and sterilization under certain conditions were referred to the Board for further study. This action was taken after the House had received a report from the Board containing the recommendations of the Committee on Human Reproduction.

The House did suggest that the AMA can "render a district public service in this matter by conferring with other interested groups such as lawyers, clergy, sociologists, legislators and government administrators."

It concurred in the reference committee's report that "it is not appropriate at this time for the AMA to recommend the enactment of legislation in this matter (abortion) for all states. The problem is essentially one for resolution by each state through action of its own legislature."

The report also stated that "it is true that there are medical implications in such legislative decisions; physicians in each state should freely provide information and guidance on these medical implications. However, enacting laws to integrate the medical aspects with the moral, ethical, religious, economic, social tradition, and other aspects of the problem is clearly the exclusive prerogative and the responsibility of the legislature of each separate state."

In its report the committee said the problems of sterilization "appear subject to the same general considerations as the problems of abortion."

On the problem of contraception the House reaffirmed its 1964 policy statement that "the prescription of child-spacing measures should be available to all patients who require them, consistent with their creed and mores, whether they obtain their medical care through private physicians or tax or community-supported health services."

It also endorsed a statement that "appropriate legislation be enacted, wherever necessary, so that all physicians may legally give contraceptive information to their patients, consistent with the policy statement of December, 1964, and with the judgment and conscience of each individual physician."

Billing and Payment for Medical Services

Eight statements on fees charged by physicians for medical services were affirmed by the House. These are applicable "irrespective of whether such fees are paid by the patient, or paid or reimbursed in whole or in part under Public Law 89-97, or any other third party plan," the House stated. Here are the eight statements:

"1. The intimate relationship between physician and patient is served best without the interposition of any third party carrier, whether in the area of diagnosis and treatment or the payment for these services.

"2. It is the patient's responsibility to deal with third party carriers in the area of financial assistance provided that the physician is at all times mindful of his obligations to the patient under Section 1 of the Principles of Medical Ethics.

"3. The physician-patient relationship is served best when there is an advance understanding regarding the payment of fees and the physician bills the patient directly for services rendered. However, the physician is ethically free to choose in each case the manner in which he is to be compensated, based upon the exercise of his independent judgment.

"4. The American Medical Association does not approve of any program which may directly or indirectly promote the charging of excessive fees or which interferes with the physician's right to charge fees commensurate with the services he renders.

"5. The American Medical Association opposes any program of dictation, interference, or coercion, whether direct or indirect, affecting the freedom of choice of the physician to determine for himself the extent and manner of participation or financial arrangement under which he shall provide medical care to patients under Public Law 89-97, or other third-party plans.

"6. It should be remembered that insurance does not create any new wealth. It merely assists in conservation. Insurance may conserve the ability of an insured person to fulfill his normal financial obligations. It does not enhance his ability to discharge added responsibilities if they are in the form of increased fees. To use insurance as an excuse to revise professional fees upward is but to contribute to the defeat of its purpose. If these indisputable and self-evident facts are not embraced by the entire membership of the profession, then it will have dealt irreparable harm to the whole movement. Also, any such failure might give impetus to whatever demand now exists for forcing rigid benefit schedules on the professional. (The foregoing is from a report of the Council on Medical Service to the House of Delegates at the Clinical Meeting in 1954).

"7. The charging of an excessive fee is unethical and is contrary to Section 7 of the Principles of Medical Ethics. The physician's fee should be commensurate with the services rendered and the patient's ability to pay. (The foregoing is from a report of the Judicial Council which was approved by the House of Delegates at the Clinical Meeting in 1960).

"8. It is not contrary to conscience for the physician to consider the patient's ability to pay if he

AMA Field Representative David Weihaupt (second from left) joined several West Virginia physicians at the annual Aces and Deuces luncheon, one of the features of the AMA Clinical Convention in Philadelphia. Others in picture (left to right) are: Dr. C. A. Hoffman of Huntington, AMA Delegate; Mr. Weihaupt; Dr. L. J. Pace of Princeton; Dr. Albert C. Esposito of Huntington, Chairman of the Council of the State Medical Association; Dr. Seigle W. Parks of Charleston, President of the Association; Dr. Richard E. Flood of Weirton, President Elect; Dr. Frank J. Holroyd of Princeton, AMA Delegate; and Dr. Richard W. Corbitt of Parkersburg, Member of the Council of the State Medical Association.

fixes his particular fee within reasonable limits. In matters relating to fees, the physician should try, to the best of his ability, to insure justice to the patient and himself and respect for his profession. (The foregoing is from an opinion of the Judicial Council in 1958)."

Membership Dues

A $25-a-year increase in membership dues, effective January 1, 1967, was endorsed by the House when it was informed by the Board that additional income will be needed by then to avoid deficit spending.

The increase, to $70 a year for the AMA's 165,000 dues-paying members, will go before the House for final action at the 1966 Annual Convention because AMA By-laws state that annual dues may be prescribed by the House only for the ensuing calendar year.

Dr. Percy E. Hopkins, Chairman of the Board, told the House that "during 1964 and 1965, the AMA will have incurred an operating deficit of more than 1 million dollars." The budget for 1966, he said, is now narrowly in balance.

The 1966 budget calls for spending some 27.6 million dollars, Doctor Hopkins reported, including almost 10½ million dollars on scientific programs, 5 million on health education and other medical service programs, more than 1 million to maintain physician records, and another million in the communication's program. Travel and meeting costs will exceed 2 million dollars.

"In a society," Doctor Hopkins said, "which has adopted inflation as a national policy and in which our system of medical care has become a pawn of politicians, it is not realistic to expect that we can limit tomorrow's programs to yesterday's income. Already demands are mounting from medical societies and physicians for a stronger and more effective AMA. These needs must be met and they must be adequately financed."

Doctor Hopkins said that AMA's income in 1960 was just under 16 million dollars, while in 1966 it will exceed 27 million, an increase of 11 million. "This represents increases of 3.9 million dollars from membership dues, 4.3 million in advertising revenue, and 2.8 million from other sources.

"During this same period," he stated, "the challenges thrust upon the Association required even greater expenditures—from 15.7 million dollars in 1960 to a need for 27.6 in 1966."

In support of the dues increase, the House noted that AMA's dues-paying members provide less than 30 per cent of the Association's income.

Gundersen Report

The House approved some of the many recommendations of the Committee to Review the Organization of the House (the Gundersen Committee) but it did not approve a number of others.

Here are the House actions on some of the committee's recommendations:

Size of the House of Delegates. Approved the suggestion that the growth of the AMA House be slowed down after it reaches 250 members. When it reaches that size, the apportionment ratio will be automatically raised from one delegate per 1,000 members, or fraction thereof, to one delegate per 1,250 members, or fraction thereof, in electing further delegates to represent each state association.

Reports of Councils and Committees. Rejected the proposal that reports of the Councils on Medical Service and Medical Education be transmitted through the Board of Trustees before being presented to the House.

Reference Committees. Adopted the recommendation that there be three reference committees by name—Amendments to Constitution and By-laws, Credentials, and Rules and Order of Business—and as many others be appointed "as may be required to consider the items of business before the House."

Tenure of Subcommittee Members of Standing Committee Approved a change in the By-laws "to limit to specified terms of one to three years the tenure of members of special committees of the councils and committees of the House, with a limitation of 10 consecutive years of service."

Committee on Medical Practices. Concurred in a recommendation that the Committee on Medical Practices be discharged with thanks and its responsibilities "be assigned by the Board to existing councils and committees."

Committee on Insurance and Prepayment Plans. Rejected a plan to make this committee a council of the Board, and the committee was retained under the Council on Medical Service.

Tenure of Office of Trustees. Turned down a proposal that would have affected the tenure of office of AMA trustees.

Affairs of Standing Committees. Directed that a By-laws change be prepared to remove the privilege of the Councils on Medical Service and on Medical Education of nominating to the Board the secretary of the respective council. Also approved the suggestion that a vice chairman be elected by each standing committee of the House.

Resolutions to House. Rejected the idea of a resolutions expediting committee and the recommendation that the deadline for resolutions be 10 days prior to the House meeting.

Federal Health Care Laws

The House took a number of actions with regard to federal health care laws passed in 1965, such as PL 89-97 (Medicare) and PL 89-239 (the Heart Disease, Cancer and Stroke Amendments). These actions included:

"That the AMA immediately seek remedial action to delete the requirement in Public Law 89-97 that a patient be hospitalized to establish eligibility for nursing home care."

"That the AMA immediately seek remedial action to amend Public Law 89-97, Part B, Title XVIII, by deleting the word 'receipted', from Section 1842—Part 3, Item B, line (ii), and substituting 'such payment will be made on the basis of a method of payment so arranged to preserve and continue the professions

current practice of billing.'" Also approved "that the AMA recommend that the Department of Health, Education and Welfare establish that an agreement for payment between the patient and physician constitutes valid evidence of services rendered."

Authorized a study of the constitutionality of PL 89-97 by calling on the Board to "take such action as may be necessary and appropriate to provide for the study and investigation of all aspects of PL 89-97 for the purpose of determining possible court action to test the legality and constitutionality of any provision or regulation issued under the law," and authorized the Board to "initiate such legal proceedings as it may deem advisable to implement the purpose and intent of this resolution."

Endorsed the Council on Medical Services' recommendation "that the state and local medical societies be urged *at this time* to assume leadership in the establishment of local advisory committees" under the Heart Disease, Cancer and Stroke Amendments of 1965. The House noted that a National Advisory Council under PL 89-239 already has been appointed by federal officials and that the AMA was not given an opportunity to recommend possible appointees to the Council. "Therefore," the House declared, "active physician participation at the state and local levels is of utmost importance."

Urged HEW to "seek consultation with practicing physicians" in formulating regulations under Title XIX as has been done under Title XVIII of the medicare law. It also instructed the AMA President and AMA Advisory Committee to HEW to "offer and urge such consultation."

Adopted a resolution that the Board "continue to seek, through all appropriate means, the implementation and administration of federal medical and health programs other than those of the Armed Forces and Veterans Administration by the Surgeon General of the Public Health Service, and especially those programs under Title XIX of PL 89-97."

Declared that the AMA Advisory Committee on PL 89-97 and 89-239 should persist in its efforts to achieve "practical recognition" by HEW of the differences between utilization review and claims review. The House adopted a report of the Council on Medical Service which said that "widespread confusion exists between the utilization review function and the claims review function." It also adopted a series of recommendations in the report aimed at clearing the confusion.

Other Important Actions

A study committee to evaluate planning techniques and development, which was established by the Board of Trustees, was concurred in by the House. The committee was given the tasks of (1) reviewing and studying current planning procedures in AMA, and (2) studying and recommending new mechanisms for organizational arrangements to achieve more effective planning and development in the future. Membership on the committee includes five Board members, the chairmen of the Councils on Medical Service, Medical Education, and Legislative Activities, the Speaker of the House, and two House members selected by the Speaker.

The Cabell County Medical Society honored Dr. James S. Klumpp of Huntington (left) at a ceremony in Huntington on November 11 for his services to the medical profession. Doctor Klumpp, a Past President of the West Virginia State Medical Association, was given a plaque. Others in picture, left to right, are: Dr. Walter R. Wilkinson of Huntington, President of the Cabell County Medical Society; Dr. Seigle W. Parks of Charleston, President of the West Virginia State Medical Association; and Dr. Jack Leckie of Huntington, President of the West Virginia Chapter of the American Academy of General Practice. (Photo courtesy The Huntington Herald-Dispatch).

Disapproval was expressed by the House of portions of the Coggeshall report, "Planning for Medical Progress Through Education," published earlier this year by the Association of American Medical Colleges. The House opposed "the basic philosophy" of portions of the report; such as:

That the AAMC should "serve as spokesman for organizations concerned with education for health and medical sciences" and "no other organization is in a comparable position to bring together and express a comprehensive view."

That "the professional aspects of education for health and medical sciences should be regarded as an essential function and fully integrated component of university organization, with decreasing dependence upon or control by organized professions and their related associations."

Wheeling Doctor Makes 'Vital' Speech

A vital speaking engagement kept Dr. D. A. MacGregor from attending the December 1 meeting of the State Board of Health.

Doctor MacGregor informed fellow board members he was to address the Twilight Club on planned parenthood.

The club is composed of men 65 to 75 years of age, he explained.

Status of Bills Reported In Legislative Bulletins

Complete reports concerning action by the Legislature on bills of interest to the medical profession are incorporated in "Legislative Bulletins" that will be sent frequently to members of the Association. The 30-day budget session opens January 12.

The Bulletins that will be mailed from the headquarters offices of the State Medical Association are timed so as to take advantage of report dates by key committees and subsequent action by the Senate and House of Delegates.

Through the use of Bulletins, we will continue to bring to our members as promptly as possible up-to-the-minute activities. These reports are, in effect, news stories that are being prepared and distributed in lieu of lengthy stories that would ordinarily appear in *The Journal.*

The final Bulletin will be mailed within a day or two after adjournment of the Legislature.

Two Physicians Are Appointed To Rehabilitation Staff

Two members of the West Virginia State Medical Association have been named to key positions on the staff of the State Division of Vocational Rehabilitation.

Dr. William S. Herold, formerly with the State Department of Health, was named Assistant Director in charge of the agency's medical services program. Dr. Kenneth L. Clark of Charleston was appointed Medical Director of the West Virginia Rehabilitation Center at Institute.

A native of Nicholas County, Doctor Herold earned A.B. and B.S. degrees from West Virginia University and received his M.D. degree in 1947 from the Medical College of Virginia. He received an M.P.H. degree in 1959 from the University of North Carolina.

Doctor Herold interned at Ohio Valley General Hospital and served a two-year residency in anesthesiology at the same hospital. During the Korean War, he served as a Flight Surgeon with the U. S. Navy.

Doctor Clark received his M.D. degree in 1950 from the Medical College of Virginia after receiving a B.S. degree from West Virginia University. He had four years of residency training in internal medicine at the University of Cincinnati, Cincinnati General Hospital.

Doctor Clark served as a Captain in the Medical Corps of the United States Air Force, 1955-57. In 1961, he was employed as a Medical Consultant in the Disability Determination Section of the State Division of Vocational Rehabilitation. The following year, he was named Chief Medical Consultant for the Section.

State Health Director Warns Of Monoxide Danger

A warning against carbon monoxide poisoning was issued by State Health Director N. H. Dyer in a recent issue of the "State of the State's Health." He noted that carbon monoxide poisoning claimed the lives of 22 West Virginians last year.

Doctor Dyer said that it is estimated that carbon monoxide poisoning ranks second to automobile accidents in the number of accidental deaths. He explained that carbon monoxide sickens and kills because it cuts off the oxygen or fresh air supply from the tissues of the body.

Doctor Dyer said that if carbon monoxide poisoning does occur despite efforts to foresee all possibilities, acting quickly can save a life. He suggests removing the victim to fresh air and beginning artificial respiration at once. Call a doctor and also send for an ambulance service. The victim should be kept warm by use of blankets, hot water bottles, or other heated devices, being sure to take precautions that hot objects are wrapped so as not to produce burns. After the victim begins to breathe again, keep him still and quiet to avoid danger of shock. Avoid use of stimulants such as coffee or tea, for these may strain the heart. Aid circulation by rubbing the arms and legs. See that the patient has rest and time to recover slowly in order to avoid any strain on the heart.

Ophthalmology Association Elects Drs. Ryan and Esposito

Two West Virginia physicians were elected to the Executive Committee of the American Association of Ophthalmology during the Association's meeting in Chicago in November.

Dr. Ralph W. Ryan of Morgantown was re-elected Treasurer and a member of the Executive Committee. Dr. Albert C. Esposito, Chairman of the Council of the West Virginia State Medical Association, was named Assistant Secretary and member of the Executive Committee.

Doctor Ryan is President of the West Virginia Academy of Ophthalmology and Otolaryngology, of which Doctor Esposito is a past president.

Doctor Villani Named Welch's 'Man of Year'

Dr. A. J. Villani was honored recently by being named Welch's "Man of the Year."

Doctor Villani was recognized for his role in community affairs at the annual Welch Chamber of Commerce dinner which was held on November 16. He was presented with a plaque by Jim Spangler, an officer of the Chamber.

Doctor Villani is active in various veterans and civic groups and has been team physician for Welch High School athletic teams for many years. He is a Past President of the McDowell County Medical Society and now serves on the Council of the West Virginia State Medical Association.

Dr. Seigle W. Parks Addresses Newsmen in Huntington

Dr. Seigle W. Parks of Charleston, President of the West Virginia State Medical Association, was guest speaker at the monthly meeting of the Ohio Valley-Kanawha Chapter of Sigma Delta Chi in Huntington on November 23.

Dr. Seigle W. Parks of Charleston, President of the State Medical Association, addressed the Ohio Valley-Kanawha Chapter of Sigma Delta Chi in Huntington on November 23. Next to Doctor Parks is Raymond Brewster, Vice President and Editor-in-Chief of the Huntington Publishing Company and President of the Chapter. Guests for the dinner meeting included Dr. John M. Bobbitt of Huntington (second from right) and Dr. Albert C. Esposito of Huntington.

Doctor Parks told members of Sigma Delta Chi, a national society of newspaper and radio and television newsmen, that the medical profession is cooperating with the federal government to implement the Medicare program.

"Although organized medicine still has the same objections to the weaknesses and defects in this law," he said, "it has offered its cooperation to bring about its most effective administration."

Doctor Parks noted that in recent months he has traveled to all parts of the state to consult with doctors and others concerned with health care.

"One problem that I felt would be uppermost in their questions would be the problem of Medicare," he said. "I am pleased to report, that if I am able to correctly interpret the reaction from the doctors I have visited in West Virginia, they are far more concerned in how we are going to obtain additional doctors to provide the medical service . . .

"As they have always accepted the responsibility of providing medical care to their patients, regardless of race, creed, color or financial ability, they individually feel that they can adapt to this governmental system, as long as it does not interfere with their responsibility to render the highest quality of medical care."

Doctor Parks reminded the newsmen that since the enactment of Medicare, representatives of the profession have had several meetings with officials of the U. S. Department of Health, Education and Welfare "to develop fuller understanding of the interpretation and implementation of this law."

Commenting on the doctor shortage in West Virginia, Doctor Parks said statistics indicate that the state has suffered a net loss of 76 physicians since 1960.

"Immediate steps must be instituted to stop this pattern of loss and to bring about corrective action," he said.

In this connection, he explained that one of his prime goals as president of the association is the recruitment of more doctors to practice in West Virginia. He said he has asked several professional and lay groups for help and has received an encouraging response.

Additional doctors might be attracted to communities which offer rent-free office space, loans for purchasing expensive medical equipment and other inducements, he explained.

Guests at the meeting besides Doctor Parks were Dr. Albert C. Esposito of Huntington, Chairman of the Council of the West Virginia State Medical Association; Mr. William H. Lively of Charleston, Executive Secretary; and Dr. John M. Bobbitt of Huntington, representing the Cabell County Medical Society.

Former AMA Counsel Elected PMA President

Directors of the Pharmaceutical Manufacturers Association (PMA) have elected C. Joseph Stetler of Washington as president of the Association.

Directors accepted the resignation of President Austin Smith, M. D., who was elected vice chairman of Parke, Davis & Company. Doctor Smith was the first full-time president of PMA, an organization of 140 companies which produce more than 90 per cent of the nation's prescription drugs.

Mr. Stetler has been executive vice president and general counsel of PMA since 1963. A native of Ohio, he received his law degree from Catholic University in Washington, D. C., and is a member of the bar in Washington and Illinois.

Mr. Stetler has served in the U. S. Civil Service Commission, the Social Security Administration, the Veterans Administration and the War Claims Commission. He also was general counsel of the American Medical Association and director of AMA's Legal and Socio-Economic Division.

Medical Technologists Plan Annual Convention

Several members of the West Virginia Association of Pathologists have been invited to speak at the 18th annual meeting of the West Virginia State Society of Medical Technologists, Inc.

The convention will be held at the Shenandoah Hotel in Martinsburg, April 21-23. The theme of the meeting will be "Unity in Action."

The social and recreational program will include tours of industrial and historical points, racing at Shenandoah Downs and a banquet on Saturday night, April 23.

Memorial Hospital Announces Cardiac Symposium

Charleston Memorial Hospital will sponsor a Cardiac Symposium at the hospital, January 20-22.

The sessions Thursday and Friday, January 20-21, will begin at 4 P.M., while the Saturday session will get under way at 9 A.M.

The program is as follows:

Thursday

"Myocarditidies"—Dr. Ralph J. Jones of Charleston.

"The Heart in Collagen Disease"—Dr. Daniel Hamaty of Charleston.

"Current Approach to Rheumatic Fever Prophylaxis" —Dr. John M. Hartman of Charleston.

"The Exercise Test After Myocardial Infarction"—Dr. W. C. Stewart of Charleston.

Dr. William C. Revercomb, Jr., will serve as moderator for the Thursday program.

Friday

"Congenital Heart Disease in the Adult"—Dr. R. J. Marshall of Morgantown.

"DC Countershock in the Treatment of Arrhythmias"—Dr. H. S. Miller, Jr., Assistant Professor of Medicine at Bowman Gray School of Medicine.

"Newer Applications of Enzymes in Myocardial Diseases"—Dr. J. H. Getzen of Charleston.

"Current Views of Lipids and the Pathogenesis of Coronary Artery Disease"—Dr. Margaret J. Albrink of Morgantown.

Dr. Albert D. Kistin of Beckley will moderate a panel discussion on the Friday program.

Saturday

"Coronary Arteriography"—Dr. Harold Selinger of Charleston.

"Surgery for Coronary Artery Disease"—Dr. James H. Walker of Charleston.

"Use of Artificial Cardiac Pacemakers"—Dr. R. J. Marshall of Morgantown.

"Present Status of Valvular Surgery"—Dr. Edwin C. Neville of Charleston.

"Cardiac Resuscitation" — Dr. Frank Medford of Charleston.

Dr. J. V. McKenzie of Charleston will moderate the Saturday program.

Additional information may be obtained by writing to Dr. Daniel Hamaty, Director of Medical Education, Memorial Hospital, 3200 Noyes Avenue, S. E., Charleston, West Virginia.

PG Course in Cancer

A postgraduate course entitled "Cancer for the Internist" will be conducted by the American College of Physicians in Chicago, February 21-25.

Fees include $60 for members of the ACP and $100 for nonmembers.

Registration forms and additional information are available from Dr. Edward C. Rosenow, Jr., Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled for the next year.

1966

Jan. 19—Soc. of Adolescent Psychiatry, New York.
Jan. 22-27—Am. Acad. Orthopaedic Surgeons, Chicago.
Jan. 23-30—Sou. Radiological Conf., Point Clear, Ala.
Feb. 1-5—Am. Col. of Radiology, Chicago.
Feb. 2-6—Am. Col. of Cardiology, Chicago.
Feb. 3-9—Cong. on Medical Education, Chicago.
Feb. 8-12—Am. Col. of Radiology, Chicago.
Feb. 14-18—Am. Protestant Hosp. Assn., Dallas.
Feb. 21-23—Am. Acad. of Allergy, New York.
Feb. 23—Nat. Multiple Sclerosis Soc., New York.
Feb. 28-March 3—Southeastern Surgical Cong., Atlanta.
March 4-9—Am. Assn. of Pathologists & Bacteriologists, Cleveland.
March 5-6—AMA Cong. on Med. Ethics & Professionalism, Chicago.
March 5-10—Int. Acad. of Path., Cleveland.
March 14-17—ACS Sectional Meeting, Cleveland.
March 18-19—AMA Rural Health Conf., Colorado Springs.
April 13-16—W. Va. Academy Oph. and Otol., White Sulphur Springs.
April 13-16—Am. Radium Soc., Phoenix.
April 14-16—W. Va. Chapter, ACS, The Greenbrier, White Sulphur Springs.
April 15-17—Am. Soc. of Int. Medicine, New York.
April 18-22—ACP, New York.
April 21-23—W. Va. Soc. of Medical Technologists, Martinsburg.
April 25-28—Industrial Med. Assn., Detroit.
April 25-30—Am. Acad. of Neurology, Philadelphia.
April 25-29—Am. Col. of Allergists, Chicago.
April 27-29—Am. Ped. Soc., Inc., Atlantic City.
April 27-May 4—Maryland Med. Soc., Baltimore.
May 1-4—American Col. Ob.-Gyn., Chicago.
May 1—Am. Fed. for Clinical Research, Atlantic City.
May 2-5—Am. Col. of Ob.-Gyn., Chicago.
May 9-13—American Psychiatric Assn., Atlantic City.
May 22-27—Ohio State Medical Assn., Cleveland.
May 22-25—National TB Assn., San Francisco.
May 23-25—Am. Thoracic Soc., San Francisco.
May 30-June 1—Am. Ophthalmological Soc., White Sulphur Springs.
May 30-June 2—American Urol. Assn., Chicago.
June 2-4—American Gyn. Soc., Hot Springs, Va.
June 23-27—ACCP, Chicago.
June 24-25—Am. Geriatrics Soc., Chicago.
June 25-26—Am. Diabetes Assn., Chicago.
June 26-30—AMA Annual Meeting, Chicago.
July 7-9—Am. Med. Women's Assn., Rochester, N. Y.
July 10-14—Med. Women's Int. Cong., Rochester, N. Y.
Aug. 25-27—W. Va. State Medical Assn., White Sulphur Springs.
Aug. 29-Sept. 1—Am. Hosp. Assn., Chicago.
Sept. 8-10—Am. Assn. of Ob.-Gyn., Hot Springs, Va.
Sept. 9—Maryland Medical, Ocean City.
Sept. 20-22—Kentucky Medical, Louisville.
Sept. 23-27—Col. of Am. Pathologists, Chicago.
Sept. 23-Oct. 1—Am. Soc. of Clinical Pathologists, Chicago.
Oct. 1-5—Am. Soc. of Anesthesiologists, Philadelphia.
Oct. 10-14—ACS, San Francisco.
Oct. 16-21—Am. Acad. of Oph. & Otol., White Sulphur Springs.
Oct. 21-23—Am. Heart Assn., New York.
Oct. 22-27—Am. Acad. of Pediatrics, Chicago.
Nov. 6-9—Med. Soc. of Virginia, Williamsburg.
Nov. 14-17—Southern Med. Assn., Washington.
Nov. 26-27—Am. Col. of Chest Physicians, Las Vegas.
Nov. 27-30—AMA Clinical Convention, Las Vegas.

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The Syndrome of Portal Hypertension and The Management of Its Complications*

Cornelius E. Sedgwick, M. D., and John K. Poulantzas, M. D.

Portal hypertension is the condition in which the blood pressure in the portal system of veins is abnormally high. The portal system drains blood from the subdiaphragmatic portion of the gastrointestinal tract, the pancreas, the spleen and the gallbladder. This system lies between two sets of capillaries: the capillaries of the gastrointestinal tract and the sinusoids of the liver. The blood collected from the former by the portal vein and its tributaries is delivered to the latter. Portal hypertension develops following an increase of inflow of blood to the portal system or an increase of resistance to the outflow. Increased inflow of blood to the portal system becomes significant in cases of arteriovenous communications in the splanchnic area (Figure 1). Increased resistance to the outflow of the blood from the portal system may be produced by a number of conditions such as (a) lesions affecting the portal vein itself and its intrahepatic portion (extrahepatic presinusoidal block), (b) lesions localized within the liver (intrahepatic presinusoidal or postsinusoidal block, or both, and (c) lesions which raise the pressure of hepatic veins (extrahepatic postsinusoidal block).

In addition to the portal blood, the liver receives blood from the hepatic artery. The portal blood and hepatic arterial blood meet and mix in the sinusoids which lie between the afferent and efferent vessels of the liver; blood then drains into a common outlet channel—the hepatic veins. The hepatic artery, of smaller size than the portal vein, carries a small volume of blood under high pressure and with great velocity, and provides about 25 per cent of the total blood supply of the liver. The portal vein carries a large volume of blood which flows slowly, under low pressure. This vessel provides the remaining

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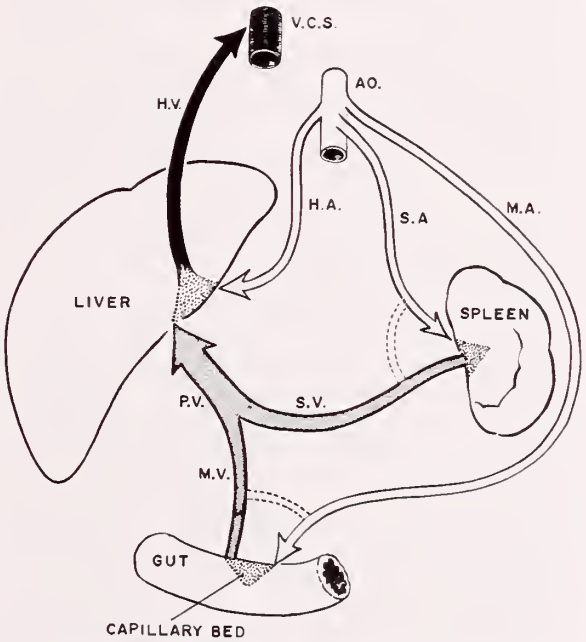

Figure 1. Inflow and outflow tracts of the portal and hepatic circulation. Abnormal precapillary communications between inflow and outflow tract of the portal system (white dotted lines) increase the volume of blood to the portal system by bypassing capillary resistance (e. g., traumatic arteriovenous fistula).

V.C.S.	= vena cava superior	S.V.	= splenic vein
H.V.	= hepatic vein	M.V.	= mesenteric vein
P.V.	= portal vein	M.A.	= mesenteric artery
H.A.	= hepatic artery	S.A.	= splenic artery

*Presented by Doctor Sedgwick before the first general scientific session of the 98th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 26, 1965.

75 per cent of the total blood supply of the liver in normal individuals at rest. Because of the higher oxygen content of the hepatic artery, the oxygen provided to the liver by that vessel is about 40 per cent of the total; about 60 per cent is furnished by the portal vein. These figures, however, vary widely, depending on variations of the metabolic processes. Apparently a relationship exists between the hepatic arterial and portal venous inflow in the normal liver. A decrease in portal flow produced mechanically by the reduction in caliber of the portal vein leads to an increase in hepatic arterial flow.

In a pathologic condition such as cirrhosis, changes take place and this interrelationship of flow is disturbed. A volume of hepatic arterial blood greater than normal flows through the liver. The fibrosis and the regenerated nodules compress the portal radicles, and the portal venous outflow is partially obstructed.[1] In addition, free communications are created between the hepatic artery and the intrahepatic portal venous radicles (presinusoidal arteriovenous fistula), with resulting marked regurgitation of blood.[2, 3] It should be emphasized that such communications between the hepatic artery and the portal vein are described in animals and patients with cirrhosis but have never been demonstrated in normal human liver (Figure 2).

In summary, the most important factors presently accepted in producing portal hypertension in cirrhosis are the increased hepatic arterial flow, the compression of the portovenous terminal branches and the production of free communications between the hepatic arterial and portal venous radicles. The diseases that may lead to portal hypertension and the type of block produced are shown in Table 1.

Table 1

Etiology of Portal Hypertension and Type of Block Produced

I. Intrahepatic Block
- A. Presinusoidal
  1. Schistosomiasis
  2. Portal infiltrates and reticulosis
  3. Sarcoidosis
  4. Congenital hepatic fibrosis
- B. Sinusoidal and postsinusoidal
  1. Laennec's cirrhosis
  2. Postnecrotic cirrhosis
  3. Biliary cirrhosis
  4. Toxic cirrhosis
  5. Hemochromatosis with cirrhosis
  6. Hepatolenticular degeneration

II. Extrahepatic Presinusoidal
- A. Thrombosis of portal vein following:
  1. Umbilical sepsis
  2. Sepsis in organs drained by portal system
  3. Thrombosis of splenic vein
  4. Intrahepatic obstruction
  5. Polycythemia
- B. Extension of normal obliterative process from umbilical vein and ductus venosus to portal vein
- C. Malignant growths in:
  1. Pancreas
  2. Stomach
  3. Colon
  4. Lymph nodes

III. Extrahepatic Postsinusoidal
- A. Obstruction of main hepatic veins (Budd-Chiari syndrome)
  1. Primary inflammation or atresia
  2. Thrombosis after rheumatic and blood diseases
  3. Secondary to tumors
- B. Secondary to increased pressure in inferior vena cava
  1. Obstruction of inferior vena cava
  2. Congestive heart failure
  3. Constrictive pericarditis

Effects of Portal Hypertension

The normal blood pressure in the portal venous system ranges between 6 mm. and 15 mm. of mercury. In portal hypertension the pressure rises above 21 mm. and may increase to 40 mm. of mercury or more. The high pressure produces anatomical and functional changes in the splanchnic circulation. The two most important effects of portal hypertension are on the collateral circulation and the spleen.

In normal subjects, the portovenous system anastomoses with the systemic circulation in the esophagogastric region, the anal canal, the falciform ligament and the retroperitoneal tissues, where the intra-abdominal organs come into contact with the retroperitoneal structures drained by the caval system. These natural portasystemic anastomoses, although present in normal individuals, are functionally unimportant. They represent potential collateral vessels and dilate in portal hypertension to divert the blood to the general circulation (Figure 3).

The portasystemic collateral circulation, which is of great clinical importance, is that in the esophagogastric region. Large, thin-walled esophageal and gastric varices develop. When these natural portacaval shunts are not sufficient to lower the portal pressure, direct trauma from ingested food or regurgitation of acid gastric secretion may lacerate or erode the varices, producing life-threatening hemorrhage.

The second important effect of portal hypertension is on the spleen. The spleen is almost always enlarged, although its size may not correspond directly to the degree of elevation of the portal pressure. When a congested spleen

has been present for a long interval, structural changes consistent with the picture of secondary hypersplenism are produced which are reflected in the peripheral blood as thrombocytopenia, leukopenia and anemia.

Investigation and Diagnosis

History and Physical Examination.—The manifestations of portal hypertension most important to the clinician are bleeding esophageal varices and ascites. When hematemesis is present, the source of bleeding must be determined. Is it secondary to ruptured varices, peptic ulceration, or does it have some more obscure cause? In patients who have bleeding varices, some evidence of hepatic disease will be present, and the history is often helpful. The presence of chronic alcoholism, infective hepatitis or other related hepatic disease suggests that cirrhosis may be the cause of portal hypertension. In one-third of 97 patients with cirrhosis operated on at the Lahey Clinic Foundation, however, no related history could be elicited. Particularly in early childhood, inflammation of the abdominal organs drained by the portal system is a frequent cause of extrahepatic presinusoidal portal block.

On physical examination, signs attributed to portal hypertension or hepatic disease, or both, may be elicited. Small or large liver, jaundice, ascites and spider nevi may be present. Splenomegaly always exists, even if the spleen is not always palpable. Gastrointestinal bleeding, especially hematemesis, associated with hepatic encephalopathy usually will indicate the diagnosis. Special investigations, however, which will confirm or exclude the diagnosis of portal hypertension are now available.

Radiology.—(a) Barium Swallow. The dimension of varices varies with spontaneous fluctuation in portal pressure and with changes in blood volume, such as after a large hemorrhage. In general, varices are apparent in the relaxed esophagus (not during the passage of a contraction wave) and when the esophagus is not full of barium since in both instances small varices are obliterated and the filling defect is overlooked. Varices are best demonstrated with the patient in the prone position; the erect position is the least useful (Figure 4).

(b) Portovenography. Portovenography was introduced in 1951 by Abeatici and Campi[5] for the investigation of portal hypertension and provides valuable information. The portovenous system with its collateral circulation and the site of obstruction of the portal vein or one if its tributaries can be outlined by portovenography. It may be performed either preoperatively, by percutaneous transsplenic puncture, or at the time of laparotomy, by cannulating a branch of the portal vein. When portovenography is done preoperatively, the surgeon can plan the optimal surgical procedure for each case. The portal pressure also can be measured just before the contrast medium is injected.

When the portal circulation is normal, the contrast medium from the splenic pulp reaches the liver within two or three seconds and only the portal and the splenic veins are outlined (Figure 5A). A filling defect, the result of a streaming

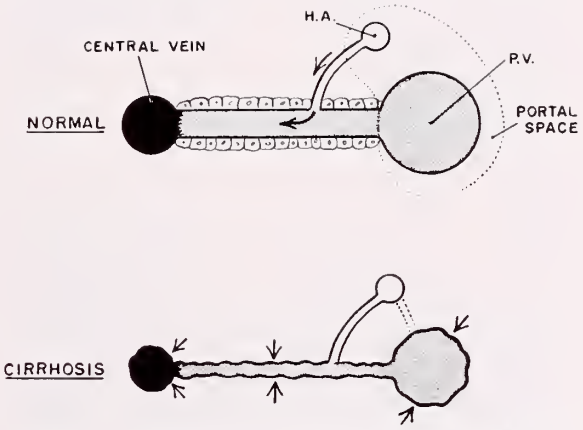

Figure 2. Mechanism of production of portal hypertension in cirrhosis. Arrows in lower drawing indicate pressure exerted on the hepatic vasculature by the fibrosis and regeneration nodules. Abnormal presinusoidal arterioportal communications in cirrhosis are indicated by dotted lines.

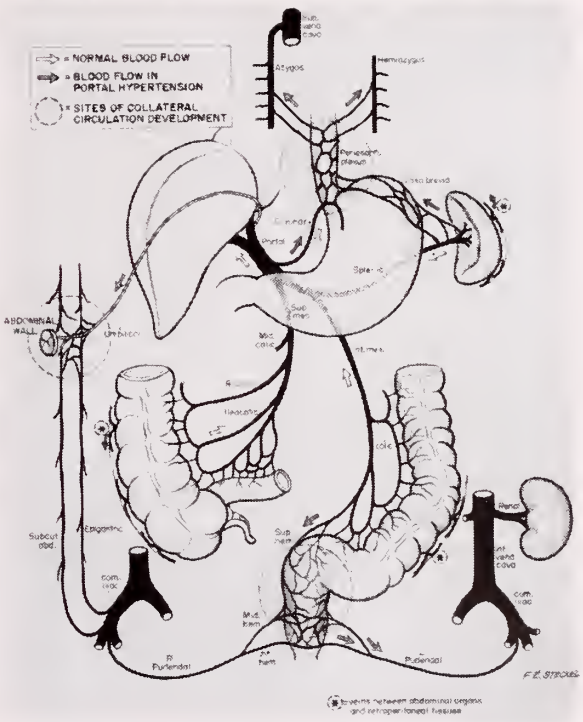

Figure 3. Anatomy of portovenous system and its potential collateral circulation with changes of blood flow in portal hypertension.

effect, is often produced at the junction of the superior mesenteric and splenic veins. A similar streaming effect may be seen in the splenic vein, and is produced by nonopaque blood entering from other branches of the spleen. False positive results may be obtained and a diagnosis of extrahepatic partial obstruction may be made in these instances. The correct diagnosis can be made, however, by operative portography. The caliber of the intrahepatic branches of the portal vein is gradually reduced from the porta hepatis to the periphery. As soon as the contrast medium advances into the sinusoids, a diffuse picture of the entire liver is obtained.

In intrahepatic obstruction, the splenic and portal veins are patent and wide. The left gastric and short gastric veins can be seen as far as the esophagus and fundus of the stomach (Figure 5B). Occasionally, a large paraumbilical vein, a large omental vein, capsular veins around the spleen and vessels to the lateral and posterior abdominal wall are filled with the contrast medium. Retrograde filling of the superior and inferior mesenteric veins sometimes may be obtained.

The portal branches within the liver are grossly distorted, but failure to demonstrate an abnormality does not exclude the presence of cirrhosis.[4]

Figure 4. Film taken after a swallow of barium. Esophageal and gastric varices are demonstrated.

In extrahepatic obstruction, the appearance varies with the site of obstruction. When it is situated at the entrance of the portal vein into the liver, a mass of small veins bypasses the obstruction (cavernous transformation of the portal vein) and the intrahepatic branches may be poorly filled. The splenic and portal veins are greatly dilated and numerous collateral channels usually are apparent.

Laboratory Tests.—Liver function tests are useful in distinguishing extrahepatic from intrahepatic obstruction and in evaluating the degree of hepatic damage.

High bromsulphalein retention, abnormal results with seroflocculation tests, low levels of serum albumin and low prothrombin time are present in intrahepatic block and very unusual in extrahepatic block.

The ammonia serum level is particularly important for differentiation of acute bleeding from the upper gastrointestinal tract. An increased ammonia level indicates that collateral circulation is present and that the ammonia from the portal blood is diverted from the liver, reaching the general circulation in great amounts. In such instances portal hypertension probably is the cause of bleeding.

Endoscopy.—(a) Esophagoscopy. Esophagoscopy has proved to be more reliable than splenic portography and oral administration of barium in demonstrating esophageal varices. Esophagoscopy is useful also as a diagnostic method for patients who have upper gastrointestinal bleeding on admission, and a decision must be made concerning the advisability of emergency surgical measures. After induction of anesthesia an esophagoscope is passed. Visualization of varices rules against the possibility of bleeding peptic ulcer, and the surgeon can then choose the most appropriate incision for the surgical procedure he contemplates.

(b) Peritoneoscopy. Peritoneoscopy is more useful for the differential diagnosis of the cause of ascites. Direct visualization through the peritoneoscope of a malignant tumor invading the peritoneal wall or with a normal appearing liver will exclude cirrhosis as the cause of ascitic accumulation.

Liver Needle Biopsy.—Liver needle biopsy is of definite value in the following: (1) apparent hepatomegaly from causes other than cirrhosis, (2) actual hepatomegaly resulting from other diseases which are not likely to produce signifi-

cant portal hypertension, (3) distinguishing between intrahepatic and extrahepatic portal vein block (in the latter, biopsy will reveal normal liver architecture) and (4) excluding hepatic disease in the presence of abnormal liver function tests.

Differential Diagnosis.—Although the diagnosis in typical cases of cirrhosis does not present a real problem, the site of bleeding must be established since patients who have cirrhosis may bleed also from gastric varices, peptic ulcer or gastritis. The differential diagnosis of peptic ulcer in a patient who does not have obvious signs of liver disease and in a patient with extrahepatic block may be difficult. Experience has shown that of the techniques available for rapid diagnosis, esophagogastroscopy is the most accurate.[6, 7]

Gastrografin (water soluble) barium x-ray series may be tried while the patient is still bleeding, but diagnostic error is relatively high. When the bleeding is torrential, a barium x-ray study often is difficult to perform and clots may obscure an ulcer. Occasionally, however, the varices may be seen.

A Sengstaken-Blakemore triple lumen tube often is helpful in establishing the diagnosis as well as in controlling the bleeding after variceal rupture. If the pressure of the balloon controls the bleeding and the gastric washings are clear, it can be assumed that the bleeding is of esophageal origin. If hemorrhage is not controlled, the source probably is within the stomach.

Treatment

Bleeding resulting from rupture of esophageal varices is the most common cause of death from upper gastrointestinal hemorrhage, and liver cirrhosis which most commonly is the underlying disease is the tenth most common cause of death in the United States.[8]

Severe hematemesis should be properly diagnosed and treatment instituted. In patients with cirrhosis, the control of bleeding is even more urgent than control of hemorrhage from any other source in the upper gastrointestinal tract because the hypotensive state increases the hazards of hepatic coma by diminishing the liver blood flow. Precipitation of coma is more threatening in these patients because of the inability of the liver to detoxify the products of blood digestion. Early determination of the source of bleeding is of primary importance in order to institute the appropriate treatment as soon as possible.

Conservative Medical Measures.—The first concern of the physician should be to restore blood loss by continuous whole blood infusions. In addition, ammonia intoxication must be avoided. Blood ammonia is the result of breakdown of proteins or blood, or both, in the large

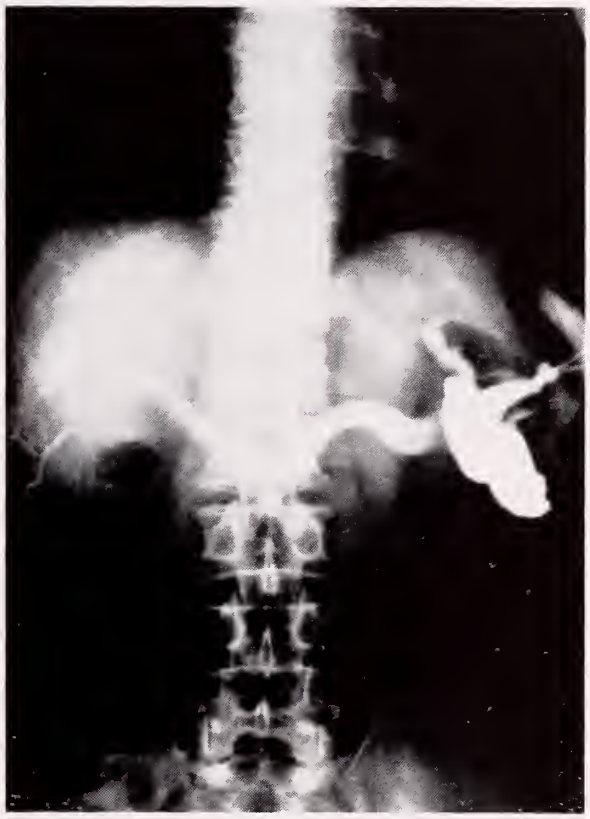

Figure 5-A

Figure 5-B

Figure 5. Portovenography. A. Normal splenoportogram. B. Splenoportogram in a patient with intrahepatic block caused by portal cirrhosis.

intestine by bacteria enzymes. The ammonia is absorbed from the intestine into the portal blood. Abnormal liver function prevents ammonia metabolism, and high ammonia levels prevail, producing ammonia intoxication. Ammonia intoxication may be prevented by elimination of the old blood from the intestine by catharsis and colonic irrigation and by giving Neomycin by mouth to decrease bacterial activity in the intestine. The caloric balance is maintained by administration of adequate amounts of 10 per cent glucose intravenously. Electrolyte balance is carefully maintained. Vitamin K_1 is prescribed when the prothrombin time is low. Occasionally, only this mode of medical therapy is employed and an acute bleeding episode may be overcome. This, however, is the exception.

Other conservative measures are in use in addition to the therapy outlined. Their main object is to stop the bleeding temporarily and allow clot formation in the bleeding veins. These measures include: (1) surgical pituitrin injections which reduce the blood inflow to the portal system and lower the portal pressure for about one hour, (2) esophageal tamponade (Sengstaken-Blakemore tube) which stops the hemorrhage by compression of the ruptured veins, (3) esophagogastric cooling which decreases the variceal blood flow and (4) correction of blood coagulation defects with epsilon-aminocaproic acid.

Despite these methods of conservative treatment used during the past 15 years, the mortality rate has decreased only slightly, remaining as high as 50 to 75 per cent, depending upon the condition of the liver.[9, 10]

Surgical Treatment of Acute Variceal Hemorrhage.—The unsatisfactory results of conservative treatment induced surgeons to seek operative means to control bleeding. Surgical procedures actually in use have the following aims: (1) reduction of the flow to the portal system (for example, ligation of the hepatic artery, splenectomy, alone or combined with interruption of the left gastric artery), (2) discontinuance of the flow of blood to the bleeding sites, (for example, porta-azygos disconnection (Figure 6), esophageal transection (Figure 7), ligation of varices (Figure 8) and esophagogastrectomy with or without intestinal loop interposition), and (3) reduction of the portal pressure by diminishing the resistance to the outflow by direct and indirect portacaval anastomoses.

Operations confined to the reduction of the flow to the portal system have proved of no value. Interruption of the hepatic artery may increase the mortality rate because of liver necrosis. Splenectomy, although temporarily reducing the portal pressure, leads to thrombosis of the splenic vein and excludes the use of this vessel later for an elective splenorenal shunt, which is the procedure of choice for patients with extrahepatic obstruction of the portal vein.

Of the surgical procedures confined to interrupting the portal flow to the bleeding sites, only the porta-azygos disconnection and transesophageal ligation of varices have been used with

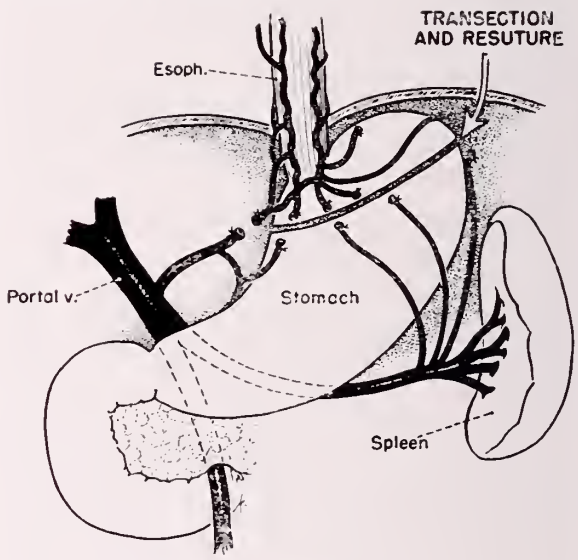

Figure 6. Porta-azygos disconnection.

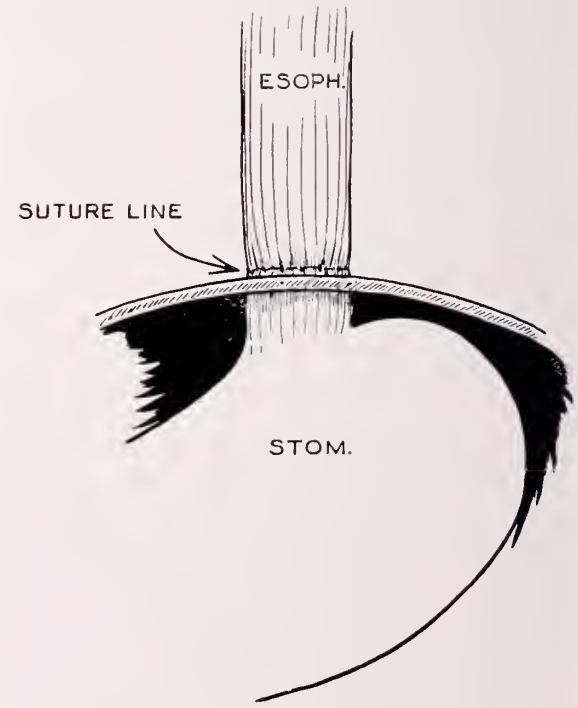

Figure 7. Esophageal transection.

acceptable results. Esophagogastrectomy is a major operation for these poor risk patients and its use should be abandoned. Each of these procedures may bring temporary relief. Bleeding will recur, however, and more definitive surgery still must be performed. The mortality rate of this type of surgical palliative treatment ranges between 15 and 75 per cent,[10-15] depending upon the degree of liver damage.

The ideal procedure for the control of acute bleeding is end-to-side portacaval shunt which, in addition, offers definitive treatment to the patient. The operative mortality ranges between 12 and 68 per cent[16, 17] and depends primarily upon selection of patients. The early high mortality rate compared with that of various palliative procedures has been considered by many surgeons to be too hazardous. The long-term results, however, prove it to be safer than any other type of treatment for acute variceal bleeding.[18]

Elective Surgery.—There is general agreement that a shunt procedure is indicated for all patients who have bled in the past from esophagogastric varices resulting from portal hypertension, and that any other type of treatment which does not reduce the portal pressure adequately is ineffective.

The mortality and morbidity associated with portasystemic shunts are directly related to the liver function. Thus, the patient who has bled and whose hemorrhage has been controlled by conservative means and the patient known to have portal hypertension who has had even a single bleeding episode should have a shunt procedure as soon as possible. The generally accepted criteria for a good risk candidate are: (1) serum albumin level above 3.0 Gm. per 100 ml., (2) bromsulphalein retention of less than 30 per cent at the end of one hour, (3) serum bilirubin value below 2 mg. per 100 ml., (4) prothrombin time after treatment with Vitamin K above 50 per cent of normal and (5) absence of ascites in the past or ascites adequately treated by medical measures before operation. When these criteria are met, the operative mortality is low and ranges from 5 to 12 per cent. A great number of patients coming for treatment do not meet these criteria, however, and a subsequent hemorrhage might be fatal because of poor liver function. We have operated on 42 such poor risk patients. The hospital mortality rate was as high as 33.3 per cent and the 5- and 10-year survival rates were 35.2 per cent and 11.1 per cent, respectively. On the other hand, 55 good risk patients underwent shunt procedures. The hospital mortality was only 9 per cent and 5- and 10-year survival rates were 67.5 per cent and 38.8 per cent, respectively.[18]

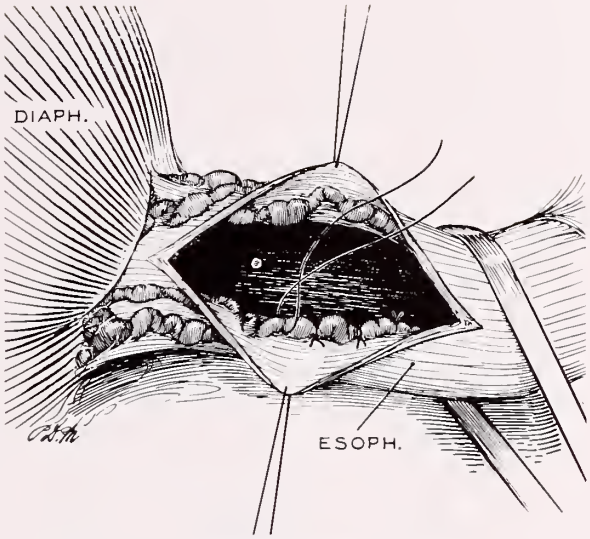

Figure 8. Transesophageal ligation of varices.

The selection of the best type of shunt in each case depends upon the site of the block in the portal system, the caliber of the vessels available for anastomosis and the presence or absence of ascites. When the block is located within the liver, an end-to-side portacaval anastomosis will best decompress the portal bed and the patient will be protected from bleeding (Figure 9). If ascites is present, however, and is a real problem, a side-to-side anastomosis (Figure 10) is preferred in order to decompress the intrahepatic portion of the portal system and to eliminate one of the factors contributing to the formation of ascites. The end-to-side anastomosis is easier to perform and less time-consuming. The incidence of portasystemic encephalopathy is generally considered lower than with side-to-side anastomosis.

An alternative operation for the treatment of intrahepatic block is the end-to-side splenorenal shunt, provided the diameter of the splenic vein is adequate (at least 1 cm.) to decompress the portal bed (Figure 11). In particular, splenorenal anastomosis is indicated in cases of biliary cirrhosis secondary to unsuccessful repair of stricture of the common bile duct. Repeated operations in this area make a portacaval shunt technically difficult. Splenorenal shunt with splenectomy sometimes also may be advisable because of severe hypersplenism. Splenorenal shunt is also the procedure of choice in cases of extrahepatic block of the portal vein, which excludes the use of this vessel for anastomosis.

Unfortunately, with extrahepatic block, which is the most common cause of portal hypertension in children and infants, the splenic vein often is of small caliber and splenorenal shunt is ineffectual. In such cases, an end-to-side shunt with anastomosis of the inferior vena cava to the superior mesenteric vein[21] (Figure 12) has been used in recent years. This procedure has many advantages; the vessels are large and sturdy and accept sutures well.

Late Complications After Portasystemic Shunt

If the patient survives a shunt, he may remain free of symptoms for a considerable period of time. This will depend upon the rate of progression of the underlying liver disease, which rate is unpredictable. A number of patients who survive more than five years have relatively static liver disease. Twelve patients had needle liver biopsy five years after end-to-side portacaval anastomosis and the histologic features of these specimens were compared with those taken at operation. No definite evidence of increase in the histologic features of cirrhosis was found.[20]

Although a portasystemic shunt best protects a patient from recurrent bleeding, there are some complications that may follow. These include recurrent hemorrhage, thrombosis of the shunt, ammonia intoxication and peptic ulceration.

Recurrent Hemorrhage.—Doubts have been expressed recently that the presence of a patent anastomosis does not necessarily protect the patient from recurrent bleeding. In a series of 50 well documented cases by clinical and autopsy analysis, 20 had repeated gastrointestinal bleeding.[22] All 50 patients had a portacaval anastomosis which was considered satisfactory at operation. Despite the fact that in 80 per cent varices were found to be present at autopsy, bleeding recurred in only 20, and the hemorrhage was caused by esophageal varices in only one case. When splenorenal anastomosis is used, bleeding may occur because this type of shunt does not always decompress the portal bed sufficiently. In our 80 survivors, the incidence of recurrent hemorrhage was as high as 21.2 per cent. After portacaval anastomosis it was only 12.9 per cent, whereas after splenorenal shunt hemorrhage occurred in 26.5 per cent. The source of bleeding was considered to be the esophageal varices in 13.7 per cent of all instances of hemorrhage, and at operation in many of these cases the anastomosis technically was inadequate.

Thrombosis of the Shunt.—When a technically satisfactory anastomosis has been constructed, thrombosis of the artificial stoma is unusual; however, a number of postoperative complications, such as subhepatic or subphrenic abscess, may lead to thrombosis. Thrombosis of the splenorenal shunt occurred in only 3 of a group of 80 patients, and in 2 of the 3, the stoma was too small.[18]

Peptic Ulceration.—Peptic ulceration may follow portacaval anastomosis, and its mode of pro-

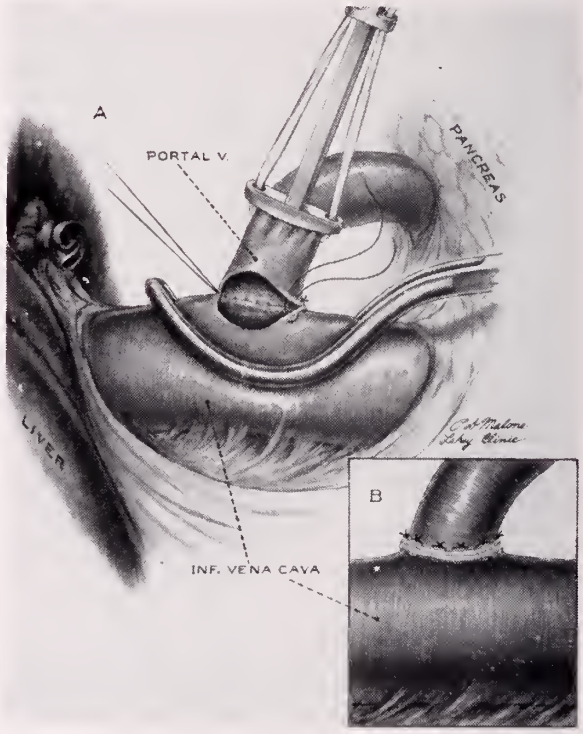

Figure 9. End-to-side portacaval anastomosis.

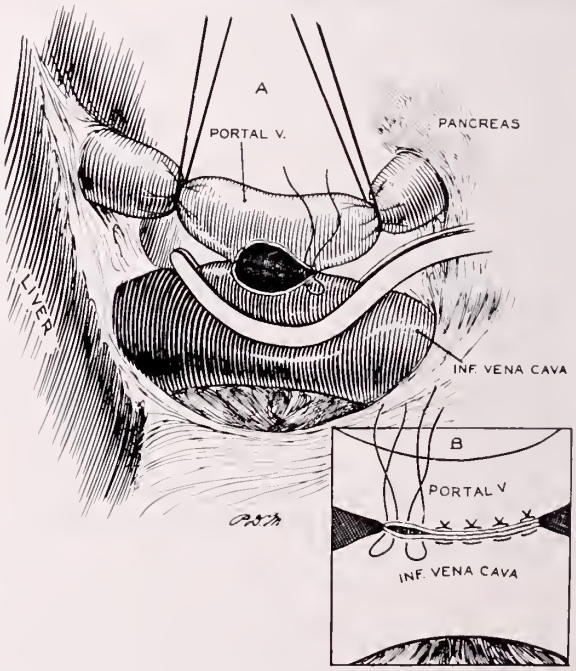

Figure 10. Side-to-side portacaval anastomosis.

duction is uncertain. In animals hypersecretion of acid from the gastric mucosa is invariably initiated after portacaval shunt.[23-25] Histamine of enteric origin has been thought to be responsible because, in bypassing the liver, this secretagogue reaches the general circulation in increased amounts. It is doubtful, however, that this same mechanism of ulcer production works in man.

In cirrhotic patients, hypersecretion is unusual after shunt procedures. Usually, the acid production remains unchanged or hyposecretion even may occur. Other factors such as diminished gastroduodenal resistance to ulcer formation from changed circulatory dynamics within the gastric wall may play a role. When hypersecretion occurs, vagotomy and pyloroplasty reduce the gastric acid secretion in man but do not halt the progression of the duodenal ulcer, with ultimate fatal bleeding.[22]

Portasystemic Encephalopathy.—Portasystemic encephalopathy is characterized by a number of neuropsychiatric symptoms including mental confusion, flapping tremor, frank organic psychosis and fetor hepaticus. Hepatic encephalopathy may complicate the course of many pathologic conditions associated with liver disease, but it is far more common after any type of anastomotic procedure for the relief of portal hypertension. The exact cause of this condition is still obscure, but accumulated evidence indicates that it is associated with abnormal ammonia metabolism or other toxic products of nitrogen-containing food digestion, or both. Ammonia is produced in the colon under the enzymatic activity of the normal bacterial flora. It is then absorbed and transported by the portal blood to the liver where it is transformed to urea, a nontoxic product. Thus, two factors may give rise to abnormally high ammonia levels in the systemic circulation: (1) inability of the liver to detoxify all of the ammonia transferred to it, as in severe fulminating hepatitis and (2) direct passage of ammonia to the general circulation through abnormal portasystemic communications. In the latter case, the condition of the liver is of primary importance because this will determine the rate at which ammonia is removed from the systemic blood. It is obvious, therefore, that natural or surgical portasystemic shunts which divert the portal blood from the already damaged liver will increase the incidence of hepatic encephalopathy, even more so when overproduction of ammonia occurs, as it does after a large protein meal or a gastrointestinal hemorrhage. When hypotension develops after hemorrhage the hazards of hepatic encephalopathy increase because the diminished blood flow to the liver results in diminished function.

The incidence of portasystemic encephalopathy after a shunt procedure varies between 4

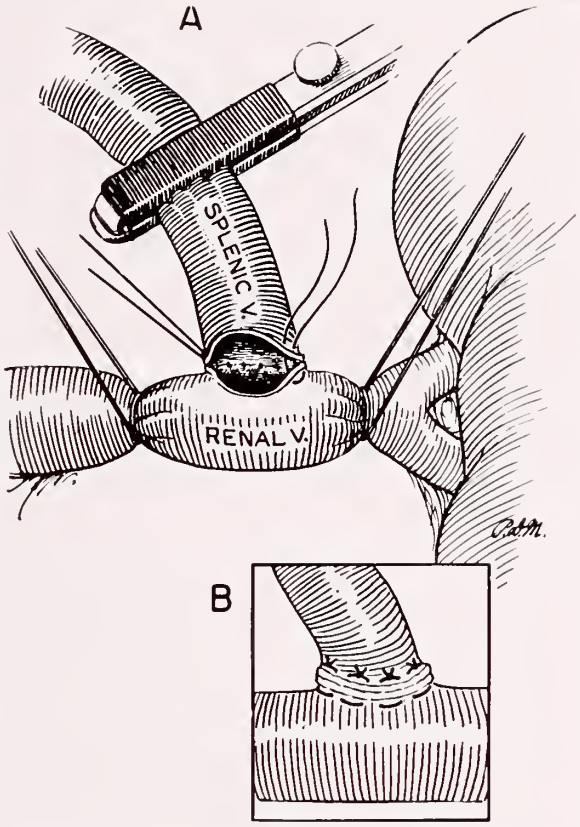

Figure 11. End-to-side splenorenal anastomosis.

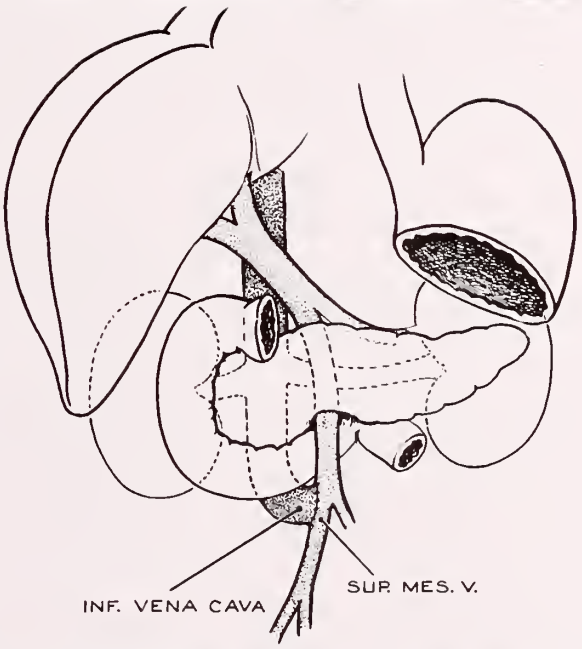

Figure 12. End-to-side inferior vena cava-superior mesenteric vein anastomosis.

per cent and 60 per cent, depending upon the condition of the liver.[26, 27] In 80 patients who survived a shunt operation at the Lahey Clinic Foundation, the overall occurrence of hepatic encephalopathy was 22.7 per cent. The difference in incidence of encephalopathy after portacaval and splenorenal anastomosis was about 5 per cent in favor of the latter.

In general, most cases are controlled by diet, avoiding meals containing large amounts of protein. In more severe cases, Neomycin in doses of 4 to 12 Gm. per day orally controls encephalopathy and permits the intake of larger quantities of protein. A balance between the necessary daily protein intake and the dosage of Neomycin has to be established in each case. Administration of this drug does not influence normal digestion and utilization of protein.

Some patients, however, cannot be treated by medical or dietary means. Recently, exclusion of the colon or colectomy has proved very useful. This operation should be performed in cases in which the single major problem is uncontrollable portasystemic encephalopathy, and not in those of patients with advanced hepatic insufficiency.[28-30]

Summary

The pathogenesis and etiology of portal hypertension have been reviewed. The effects of high blood pressure within the portal system and the available methods of investigation of this syndrome are discussed. Particular emphasis is placed on the differential diagnosis and conservative and surgical treatment of acute variceal bleeding. The principles of evaluation of patients for elective definitive surgical therapy and the choice of shunt procedure to be used are outlined. Finally, the possible late complications of the survivors of shunt procedures are discussed.

A list of references may be obtained by writing to The Journal.

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Cardiac Arrest in the Community Hospital*

Frank E. Medford, M. D.

In just a few years cardiac resuscitation has progressed from an occasional attempt in the medical center to a common procedure in the community hospital. The report on external cardiac massage by Kouwenhoven, et al.[1] seems to have created the impetus responsible for this change, and the development of defibrillators, some of which are very mobile,[2] and a variety of pacemakers[3] have provided the medical profession with the necessary tools for a basic program in cardiac resuscitation. As physicians have become more aware of these advances, they have come to realize that patients with electrical instability and conduction abnormalities of the heart need not necessarily die. The physicians at Memorial Hospital have recognized the importance of the community hospital in the management of cardiac arrest, perhaps out of necessity, since this is one condition in which the patient cannot be referred to a medical center. Results of cardiac resuscitation in this community hospital are encouraging and are the basis of this report.

The Author

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Materials and Methods

All charts coded as cardiac arrest, ventricular fibrillation, ventricular standstill or cardiovascular collapse, from August, 1960, through January, 1965, were studied. Cardiovascular collapse included cases of ventricular tachycardia and idioventricular rhythms associated with profound shock. The Department of Anesthesia keeps records of all resuscitations attended by its members and these records were searched for additional cases. Only cases in which the arrhythmia was demonstrated by thoracotomy, electrocardioscopy, electrocardiography or insertion of a spinal needle through the chest wall were included.

A cardiac resuscitation cart containing all necessary drugs and equipment was assembled and a routine established in February, 1963. The management of the various arrhythmias varied somewhat but generally followed the principles outlined in previous reports.

Results

Fifty-six patients were found to meet the requirement of a definitely diagnosed arrhythmia. These were equally divided between females and males with an age range of 7 weeks to 91 years, a median age of 60.0 years and a mean age of 56.8 years. There were 51 caucasians, or 91.1 per cent and 5 negroes, or 8.9 per cent, which are about the same as general admission percentages. The distribution of arrhythmias is shown in Table 1. Two cases of ventricular fibrillation also are included in the ventricular standstill group since in these prolonged ventricular standstill occurred after defibrillation. Likewise, two cases of ventricular fibrillation are included in the cardiovascular collapse group since idioventricular rhythms with collapse occurred in these after defibrillation. Most of the cardiac arrests occurred on medical wards followed by the emergency room and intensive care unit. Patients with nonsurgical conditions accounted for 48, or 87.5 per cent of the arrests.

Fifty per cent of cardiac arrests occurred in acute coronary occlusions with the next three most common causes being hypoxia, drug reac-

Table 1

Distribution of Arrhythmias in Cardiac Arrest

Ventricular fibrillations	37 (66.1%)
Females	19 (51.4%)
Males	18 (48.6%)
Age range	19.0 mo. - 78 yr.
Mean age	56.9 yr.
Median age	62.0 yr.
Ventricular standstills	14 (25.0%)
Females	6 (42.9%)
Males	8 (57.1%)
Age range	41.0 yr. - 75 yr.
Mean age	58.1 yr.
Median age	60.0 yr.
Cardiovascular collapses	9 (16.1%)
Females	5 (55.6%)
Males	4 (44.4%)
Age range	7.0 wk. - 91 yr.
Mean age	54.4 yr.
Median age	60.0 yr.

*Presented on Education Day at Charleston Memorial Hospital on June 25, 1965.

Submitted to the Publication Committee, June 22, 1965.

tion and pulmonary embolus. Most often the electrocardiograph was used to diagnose the arrhythmia. Diagnostic thoracotomy was used in eight instances and a needle inserted into the heart in four.

In the entire group ten patients, or 17.9 per cent, lived to be discharged. In those with ventricular fibrillation, 8, or 21.6 per cent were discharged, and in the ventricular standstill group, excluding the 2 postdefibrillation cases, 1, or 8.3 per cent, were discharged. Only 1 cardiovascular collapse was discharged, and excluding the 2 postdefibrillation cases, yields a discharge survival rate of 14.3 per cent. There were only 3 discharge survivals prior to assembly of the resuscitation cart and establishment of a routine. It is of interest that there were no survivals in those patients having thoracotomies.

In the 28 cases of acute coronary occlusion six survived to discharge yielding 21.4 per cent. Five, or 23.8 per cent who fibrillated and 1, or 20.0 per cent, of those suffering from ventricular standstill, excluding two cases of prolonged standstill resulting from defibrillation and included in the fibrillation group, were discharged. There were no discharge survivals in cases of cardiovascular collapse occurring in acute coronary occlusion.

The only significant complication of resuscitation was fractured ribs or costochondral joints, which occurred in 10 instances. In two patients ventricular rupture occurred; in both anticoagulants were used and rupture occurred in areas of infarction.

Previous electrocardiograms were available in 33 cases. In 9 there was evidence of old myocardial infarction. Only 4 of the tracings were interpreted as normal, and a wide variety of findings was reported in the remainder.

It is significant that 28 cases were managed by medical residents alone; internists assisted the residents in 9 other cases and surgeons assisted in 3.

Discussion

Previous reports of cardiac arrest appear in Table 2, and it can be seen that our survival rates compare favorably with these.

Although exact timing was recorded in only a few of our cases, the paramount importance of early diagnosis and immediate correction of the cause of the cardiac arrest has been evident. It has been shown that early detection of cardiac arrest is best accomplished by constant monitoring of high-risk patients, and coronary care wards have been established to provide this service.[12] The following case demonstrates the necessity of monitoring high-risk patients.

Case Report

A 49-year-old safety director was brought to the emergency room with severe anterior chest pain. He was pale, with a blood pressure of 60/0. An electrocardiogram showed an acute inferior wall myocardial infarction. While taking the tracing, a short burst of ventricular fibrillation appeared in Lead V_3. Intravenous metaraminol was started, and a cardiac-arrest standby requested. Three minutes after attaching the cardiac monitor he suffered ventricular fibrillation which immediately responded to 500 volts AC for 0.15 seconds. Thereafter he was monitored constantly, and three more bouts of ventricular fibrillation required countershocks of 200 watt-

Table 2

Reports on Cardiac Arrest

Author, et al.	Year	Total Cases & Surv.	Vent. Fib. & Surv.	Vent. Standst. & Surv.	C V Collapse & Surv.	Comment
Kouwenhoven[1]	1960	20-14	3			no definite diagnosis in 17
Jude[2]	1962	10-3	10			
Moss[4]	1962	3-3	3			3 selected cases
Conway[5]	1963	17-4				3 with pul. edema did not survive
Klassen[6]	1963	126-13.5%	37%	63%		60 cases were myocardial infarct
Keevil[7]	1963	5-2	5			all coronary art. disease
Johnson[8]	1963	49-5				no mention of types
Jordan[9]	1964	100-3	21-0	47-1	32-2	
Kaplan[10]	1964	100-11	33-6	65-5	2-0	
Himmelhoch[11]	1964	65-4	29%			diagnosis in one surv. not proved
Author's series	1965	56-10	37-8	12-1	7-1	

seconds DC. He recovered and was working full time two months after discharge.

Without monitoring equipment, early diagnosis of an arrhythmia is difficult but as demonstrated by the following case is not impossible.

Case Report

A 67-year-old man with a history of an old myocardial infarction was brought to the emergency room late at night in severe pulmonary edema. As morphine sulfate was being administered intravenously, he collapsed, and no blood pressure, pulse nor heart beat could be detected. A spinal needle was inserted through the chest wall while resuscitation measures were instituted. The needle was noticed to have a fine, oscillating movement interpreted as ventricular fibrillation. He was countershocked with 750 volts AC for 0.15 seconds, after which the pulse and blood pressure immediately returned. Treatment for the congestive failure was continued, and he was discharged two weeks later.

Comment: To our knowledge this is the only documented survival of a patient having ventricular fibrillation during acute pulmonary edema. The accuracy of the diagnostic method may be questioned in this case but we have in several instances confirmed the transthoracic needle technique by simultaneous electrocardiography. Due to the possibility of coronary artery damage, this method probably should be used only when others are not available.

The urgency of correction of the arrhythmia is equal to that of diagnosis, as shown in the following case:

Case Report

A 47-year-old bottle inspector was admitted to the emergency room with severe anterior chest pain. The electrocardiogram showed an acute inferior wall myocardial infarction. He was given meperidine, and oxygen was administered through a nasal catheter. About three minutes after the oxygen was started, he gasped, and no blood pressure, pulse nor heart beat was detected. He was placed on the floor, and external cardiac massage and mouth-to-mouth breathing were started. A diagnosis of ventricular fibrillation was made just as intubation was begun. The anesthetist was instructed to discontinue intubation, and the patient was countershocked with 750 volts AC for 0.15 seconds, with immediate reversion. A few hours later a monitor showed the patient had ventricular tachycardia. He was given 2,700 mg. of pronestyl by vein over a period of twenty minutes followed by 360 mg. quinidine sulfate intravenously. A few minutes later sinus rhythm resulted. He was discharged four weeks later.

Comment: This radical drug therapy was deemed necessary since the DC defibrillator was not available for reversion of the ventricular tachycardia.

Artificial ventilation and external cardiac massage have not been emphasized so far in this discussion. These maneuvers certainly are better than doing nothing in the early period of resuscitation when the diagnosis is yet to be made and no measures are yet available to correct the abnormality. In fact,[13] others have reported and we have had several spontaneous reversions of ventricular fibrillation following artificial breathing and external cardiac massage. Del Guercia,[14] et al. have demonstrated that mean arterial pressure and cardiac indices are very low during external cardiac massage. It would appear that these procedures, although of some value, should not be allowed to create a false sense of security.

The use of various drugs has been adequately discussed elsewhere, [15, 16, 17, 18] and only a few comments will be made here. Shock in myocardial infarction is treated early, since on numerous occasions cardiac arrest was noted to follow hypotension. Metaraminol has generally been the first vasopressor used, but one should not hesitate to change to other vasopressors if no response occurs within 10 to 15 minutes. In five of our cases it was noticed that ventricular fibrillation occurred in patients with myocardial infarction just after oxygen was started. The possibility that oxygen may precipitate arrhythmias has been reported previously,[19, 20] and one wonders if oxygen should not be used more judiciously in patients with myocardial infarction.

It has been reported that DC countershock in ventricular fibrillation is more effective than AC countershock.[21, 22] In only a few cases in this series have both modalities been utilized, but the impression is that DC countershock is more effective.

Other than vasopressors, the most commonly used drug in this group was pronestyl which seems to be the drug of choice in multifocal premature ventricular contractions, recurrent ventricular fibrillation, ventricular tachycardia and some supraventricular arrhythmias. Atropine intravenously was used on occasion in atrioventricular blocks thought to be due to increased vagal tone. Corticosteroids were used often, especially in severe shock and in atrioventricular

conduction defects thought to be secondary to inferior or posterior wall myocardial infarctions. In myocardial infarctions with cardiac arrest, anticoagulants often were used, but in patients who received vigorous external cardiac massage, the use of anticoagulants was postponed for 24 or more hours.

Intra-arterial blood transfusions, often oxygenated with peroxide, have been advocated by some.[23] We have not tried these measures, but perhaps they should be considered more strongly.

It often has been stated in our institution that resuscitation itself is the easiest part of management and that the postresuscitation period is the most difficult. Arrhythmias are very prone to recur, and for this reason the patient must be watched very closely. Infections, especially pneumonias, must be treated promptly. Tracheostomy often is necessary because of infection and large quantities of secretions. Fluid, electrolyte and acid-base balances must be managed with meticulous care. In many cases with moderate to severe hypoxia, hypothermia should be considered. And finally the patient must be gradually rehabilitated.

The success of cardiac resuscitations really depends on three factors. Adequate facilities must be obtained and a routine established to care for patients who develop cardiac arrest. Last, but most important, house officers must be trained to deal with cardiac arrest.

Summary

The records of 56 patients who had cardiac arrest due to a definitely diagnosed arrhythmia were studied. Forty-eight of these patients were nonsurgical admissions. Of 37 who had ventricular fibrillation 8 survived. One of the ventricular standstills and one of seven cases of cardiovascular collapse survived. One-half of the cardiac arrests occurred in patients with acute myocardial infarction. Twenty-one of these had ventricular fibrillation and five survived. Of five ventricular standstills in acute coronary occlusion, one survived. There were no survivors in the cardiovascular collapse group with acute coronary occlusion. Monitoring of high-risk patients, early diagnosis and rapid treatment of the arrhythmia are of primary importance. External cardiac massage was of questionable benefit, and its use should not create a false sense of security and thereby delay diagnosis and definitive treatment. Facilities and a well-planned program for the care of patients with cardiac arrest should augment house staff training, which is most important.

A list of references may be obtained by writing to The Journal.

Clinical Investigation—Government Style

A new drug may not be shipped across state borders for administration to a human until the sponsor of the drug (who may be the investigator) has filed a request for exemption for such use with the FDA. He must describe and identify the source of the drug and its manufacturer; he must describe previous animal studies with the drug to show that it is reasonably safe to initiate human studies; he must give evidence of his professional qualifications and his facilities for investigation. Finally, the investigator must certify that he will obtain consent from the persons receiving the drug except where this is not feasible or, in the investigator's best judgment, is contrary to the best interest of the subjects.

The sponsor must also make progress reports at appropriate intervals, not exceeding a period of one year. He must promptly report any adverse effect which is reasonably regarded as due to the drug. He must maintain records for a period of two years after the drug has been approved or disapproved, or after his investigations have been discontinued. Joseph F. Sadusk, Jr., M. D. to Association of Military Surgeons.

Special Article

Screening in a Rural Setting

Marilyn A. Jarvis, M. D.

UNIVERSAL problems in effective screening procedures are getting people to avail themselves of the tests and, secondly, having them understand the value of the results. With these in mind, a combination program was requested to instruct women in the meaningfulness of screening tests and to demonstrate sample procedures.

Cooperation among personnel of various state, county and local groups led to the development of a 1½-day rural health conference at Washington-Carver Camp in Fayette County, West Virginia, June 7-8, 1965. These contributing groups included the state and county personnel of the Cooperative Extension Service, West Virginia University Appalachian Center, County Health Departments, State Departments of Education, Health, and Mental Health, Fayette County Unit of the American Cancer Society, a private industry, local physicians and the Division of Preventive Medicine at the West Virginia University Medical Center.

Women attending were homemakers from the primarily rural areas of Fayette, McDowell, Mercer, Kanawha, Raleigh, Nicholas and Wyoming counties (Table 1).

Lectures, discussions, exhibits, films and slide presentations by staff of the various agencies were designed to inform the women of their role as promoters of family health. Lecture topics included: "Serving Community Meals," "Immunizations," "Dental Health," "Understanding Ourselves" (sex education), "Available Health Services," "What is Your Responsibility to Yourself and Family?," and "Promoting Mental Health in Children and Youth" (Complete program and list of speakers available upon request to the author).

Four types of screening tests were discussed and demonstrated. Since the prime interest of the conference planning committee was health education rather than service, great care was used to inform the participants about the usefulness and limitations of screening tests. In all areas, emphasis was placed upon seeing the family physician for a complete physical examination and interpretation of screening test results. Screening tests offered were: visual acuity at 20 feet using the Snellen Chart, single blood pressure reading taken with the patient in erect position, testape reading of post-prandial urine specimen and cytological examination of cervical smears.

Submitted to the Publication Committee, September 17, 1965.

The Author

- **Marilyn A. Jarvis, M. D., Instructor, Division of Preventive Medicine, West Virginia University School of Medicine, Morgantown.**

Procedure.—Registration at the door of the screening test building was managed by cooperative extension agents.

Participants then rotated through the various areas to read the eyechart, have their blood pressure taken by a county public health nurse, donate a urine specimen, and then report for cervical smear collection. Details of the cervical smear collection will be discussed in depth as an example of methodology of screening in a rural setting.

Equipment.—An ordinary four-legged 2′ x 4′ wooden table, found at the camp, was used for the examination table. It was covered by a bed sheet and disposable paper which was changed between patients. Patients were put in the lithotomy position by placing their heels on the end of the table. For the simple collection of cervical cells, stirrups are not necessary. The county health nurse furnished a goose-neck lamp from her office.

Disposable plastic vaginal speculums were used without lubricant. In only one case was it necessary to moisten the speculum with tap water to facilitate insertion. The examiner (the author) used throw-away finger cots and spatulas. Slides and spray were donated by the Can-

cer Society. Mail-in packages and identification cards were furnished by the Department of Pathology of the West Virginia University Medical Center where slides were read for the usual mail-in fee.

Results.—Of the 53 women requesting Papanicolau smears, all were reported as "negative, absence of abnormal or atypical cells (Class 1)." Table 2 explains the results of the cervical smear examination by age group of participants.

Fifty-seven per cent of the women had not had previous Pap smears because of lack of accessibility of the medical service, ignorance of the need, or because of fear of the technique. The latter two reasons were, hopefully, dispelled by the lectures and demonstrations.

The fact that all the smears were negative does not in any way detract from the validity of the test. In large population groups about 1 per cent positives are expected.

Follow-up.—The names of the family physicians were requested from all the participants so that an explanatory letter, together with results of the tests, could be sent to the physicians. All participants were urged to consult with their physician concerning the test results; in fact, this is the *only* way the results would be made known.

Family physicians were requested to mail in a pre-printed postcard when the patient reported for consultation. To date 13 cards have been received.

Other tests.—Table 3 shows the results of other tests offered. Not all women requested the entire battery as some were not convinced of the necessity, were afraid, or were unconcerned.

Discussion.—Not all women attending the conference participated in the screening tests. Some may have recently had medical care although the majority were from rural areas where transportation and money are scarce. A three dollar fee was collected for the pathologist's cytological interpretations, an amount which may have hindered some participants.

The object of the conference, however, was *not* to perform services but to create an awareness in the homemaker of her responsibility in leading her family toward healthful living. It is hoped by her first-hand knowledge of the simplicity, painlessness and usefulness of these tests as demonstrated at the conference, she will urge her family to see the family doctor for early diagnostic examinations.

Summary.—Screening tests are recognized as valuable tools in comprehensive medical care. Too often such tests are offered only where available facilities are optimal. This project demonstrates the simplicity of management of four screening tests, offered in a camp facility. The cost of the disposable equipment was borne by donations, the staff was on loan from various county and state agencies, and the participants were rural homemakers.

Table 1

Population of Towns Given as Mailing Address by Women Screened at Washington-Carver Camp, June 7-8, 1965.

Population**	No. of Women From That Mailing Address
< 500	39
501-1000	8
1001-1500	5
1501-2000	8
> 2000	7
Total	67

** 1960 Census, Bureau of Census, U. S. Department of Commerce

Table 2

Results of Cervical Smear Examination by Age and Menopause History of Women Participants Screened at Washington-Carver Camp, June 7-8, 1965.

Age	No. Having Cervical Smears	No. Post-menopausal	No. Having Previous Smears** Yes	No. Having Previous Smears** No	No. Read As Class I	No. Reported With Inflammation Including Trichomonas
20-25	1		0	1	1	1
26-35	4	1*	2	2	4	3
36-45	9	1	4	4	9	5
46-55	15	13	8	7	15	9
56-65	14	14	5	9	14	6
66-75	8	8	2	5	8	6
76-85	2	2		2	2	1
Total	53	39	21	30	53	31

* by Subtotal Hysterectomy
** 2 No Answer

Table 3

Results of Other Screening Tests by Number of Participants, Washington-Carver Camp, June 7-8, 1965.

	Number Women By Results	Total Number Participants
Single Urine Examination for Glucose by Testape.		
Number Negative	50	
Number 4+	1*	51
Blood Pressure Readings (Erect)		
Readings under 150/90	54	
Readings over 150/90	5	59
Visual Acuity by Snellen Chart		
20/30 or Better Both Eyes	4	
Worse than 20/30 in One Eye or Both	11	15

*Known Diabetic

Etiology and Management of Acute Brain Swelling

Thomas W. Langfitt, M. D.

Brain swelling continues to represent a major problem in many disease states affecting the central nervous system. It may occur as a result of any major insult to the brain including most notably head trauma, subarachnoid hemorrhage, and following major intracranial surgery. Cerebral swelling also occurs with anoxic or ischemic anoxia and in systemic poisonings, such as lead intoxication.

Many of the present concepts regarding the etiology of cerebral swelling originated in the 19th century. Pathologically "dry" and "wet" brains were described; the former was termed brain swelling, and the wet brains were considered to represent true cerebral edema. Thus, the concept of intracellular and extracellular cerebral swelling was developed, and in recent years distinction of these two forms of edema has been further clarified by electronmicroscopy.

The state of the cerebral vasculature is another factor which influences brain volume and, in turn, intracranial pressure. We have demonstrated in the monkey that experimental head trauma and cerebral compression with an extradural balloon can cause brain swelling sufficient to raise the intracranial pressure to the level of the blood pressure and permanently abolish cerebral blood flow. Also, the swelling is due at least in part to a paralysis of the vasoconstrictor tone of cerebral vessels, permitting passive dilatation and a many-fold increase in intravascular cerebral blood volume. Heretofore, it has been assumed, with rare exceptions, that cerebral swelling is due entirely to cerebral edema, and therapy has been directed toward reducing the water content of the brain (hypertonic solutions, hypothermia, corticosteroids). If cerebrovascular dilatation contributes to this process, measures to reverse the vasodilation should reduce the brain swelling and cause a fall in intracranial pressure.

In order to investigate this aspect of the problem pressure has been recorded continuously from a catheter in the cerebral subdural space in 50 post-operative craniotomy patients. Enormous fluctuations in intracranial pressure were observed, confirming the animal experiments. Simultaneous recordings of lumbar subarachnoid pressure were also obtained, and in four patients intracranial pressure exceeded 1300 mm. CSF at a time when lumbar tension was normal. This emphasizes the caution which must be exercised in interpreting spinal fluid pressures.

The most potent cerebral vasodilators are hypoxia and hypercapnia, and we found that marked rises in intracranial pressure could be aborted or reversed by assisting the patient's respirations, or in severe problems, by hyperventilation with high oxygen concentrations. If brain damage was extensive, however, neither this method nor the usual means of combating cerebral edema was adequate to prevent irreversible brain swelling.

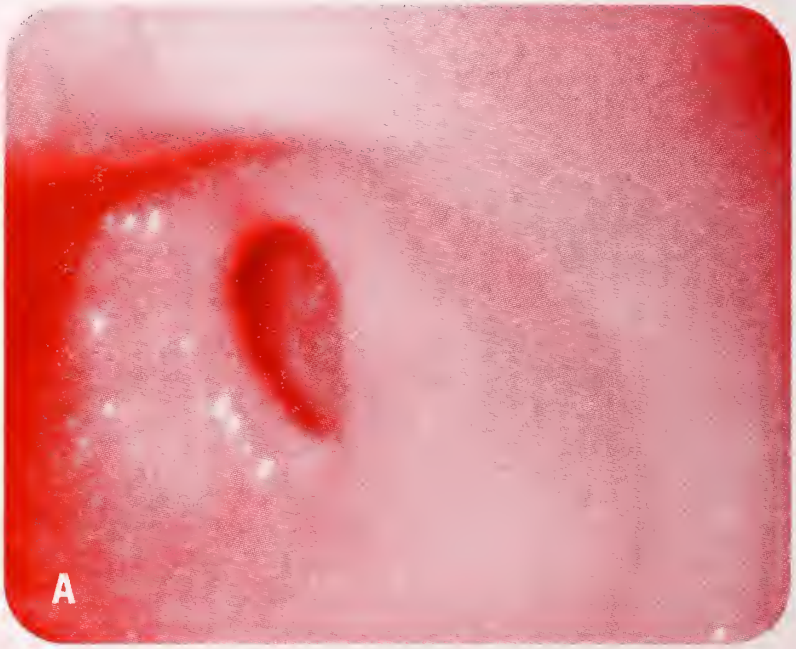
In conclusion, excessive cerebral vasodilation, in addition to edema, should be considered as a cause of the cerebral swelling which may follow various forms of brain trauma. Since it appears that the vascular factor in brain swelling is responsible for the rapid increase in intracranial pressure and sudden neurological deterioration observed in our patients, immediate tracheal intubation or tracheostomy and respiratory assistance are recommended in patients who appear to be in danger of dying from a major cerebral insult.

The Author

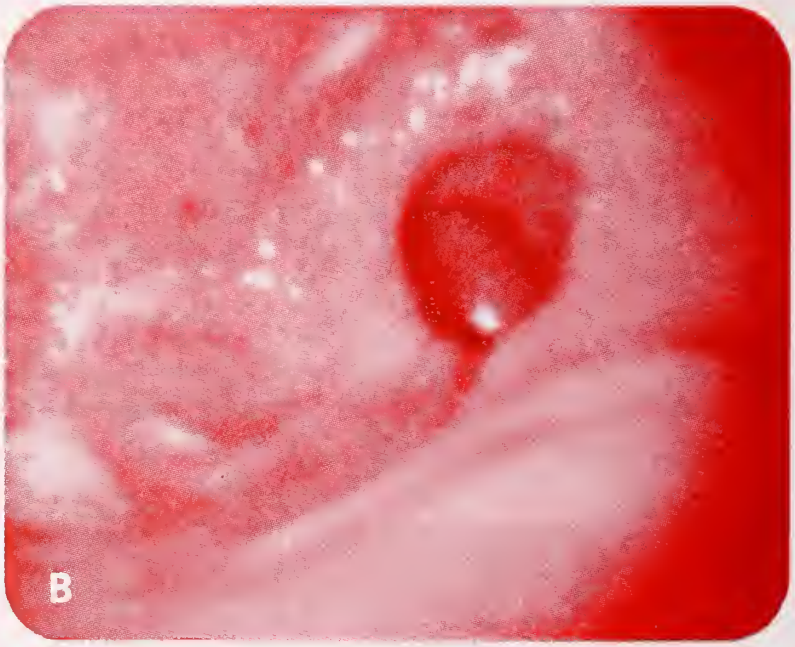
- **Thomas W. Langfitt, M. D., Head, Department of Neurosurgery, Pennsylvania Hospital, and Assistant Professor of Neurosurgery, University of Pennsylvania School of Medicine, Philadelphia. The author is the son of Dr. Frank V. Langfitt of Clarksburg, a Past President of the West Virginia State Medical Association.**

Submitted to the Publication Committee, October 27, 1965.

A list of references may be obtained by writing to The Journal.

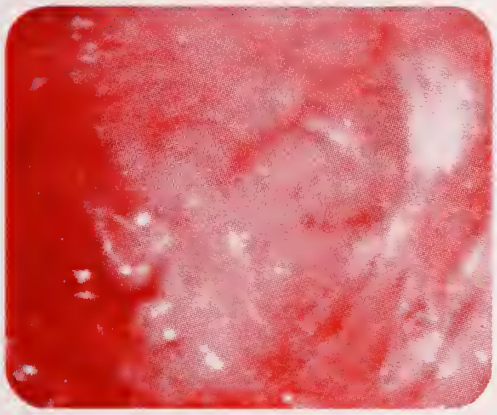


Which Is Pyloroplasty with Vagotomy?
Which Is Pro-Banthine?



Photographs—Harry Barowsky, M.D., Lawrence Greene, M.D., and Robert Bennett, M.D., from a Scientific Exhibit presented at the Annual Meeting of the American College of Gastroenterology, Bar Harbour, Florida, Oct. 24-27, 1965.

Another example of Pro-Banthine® (propantheline bromide) a true anticholinergic in action



Normal relaxed pyloric antrum; contracted pylorus (pyloric fleurette)

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Side Effects and Contraindications: Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. Pro-Banthine is contraindicated in patients with glaucoma, severe cardiac disease and prostatic hypertrophy.

SEARLE

Research in the Service of Medicine

The President's Page

WHAT TO DO—UNTIL MEDICARE COMES

STATED as simply as possible, the most positive step is to begin at once to develop and implement Utilization Committees. Regardless of the outcome of Medicare, the quality of medical care and the effective use of hospital beds and services can be materially increased for all patients, in direct proportions to the skill and proficiency of each hospital's Utilization Review Committee.

We are informed by H.E.W. that for any hospital to be approved as a qualified provider of services, it must produce evidence that it has a functioning Utilization Review Committee or its equivalent.

Mr. Arthur Hess, Director of the Bureau of Health Insurance of the Social Security Administration, stated, "As I see the emerging concept of utilization review it has one compelling justification—it is the way in which doctors, working together and accountable to each other, can assure that each patient in the light of medical necessity will have fair access to and an optimum use of scarce and expensive facilities."

There will be two kinds of reviews for which the Utilization Review Committees will be responsible.

The first kind, which is essentially educational in nature, would be to look into the various elements of utilization—admissions, services provided, and lengths of stay—from the standpoint of their medical necessity.

The second kind of review would be of the individual beneficiary remaining in the institution for a period of extended duration, to determine whether further in-patient services are medically necessary. Each hospital's Utilization Review Committee must decide what number of days constitutes prolonged stays, and then within one week following the last day of such a period will conduct its review and recommend whether further stay is indicated; but if it determines it can no longer justify the medical necessity, it will confer with the attending physician. If they agree, then arrangements for discharge will be made. If they disagree and make a conclusive finding that continued hospital care is not medically necessary, the Social Security Administration is relieved of the liability of paying for such further care after the third day following the day the institution receives notice of such findings.

It is felt that there are several sources of information which every committee will want to study, including the talk presented by Arthur Hess to the AMA in Philadelphia on November 27, 1965, and the handbook, "Utilization Review," both of which, as well as other instructional material, may be obtained from the AMA Council on Medical Services, Committee on Medical Facilities, 535 North Dearborn Street, Chicago, Illinois 60610.

There is no need to procrastinate any longer as this is one of the most progressive and acceptable side benefits that has been stimulated by the implementation of the Medicare program. Fortunately and to their credit, many hospitals have developed and have in efficient operation Utilization Review Committees; others will need to expand this activity. One guiding principle should be that all patients will benefit from this procedure, not just Medicare beneficiaries.

It was further pointed out by Mr. Hess that the hospital administrative costs incurred in connection with the implementation of the utilization review plan will be includable in the definition of reasonable costs and will be reimbursable to the extent that such costs relate to health insurance program beneficiaries. This may include a full-time or part-time secretary in the Medical Records Department. Compensation for the chairman of this committee may be considered a reasonable cost.

As the Medicare implementation program will become more complex in the next few months, it is a reasonable statement that one of the first steps at the present time is to develop Utilization Review Committees for each hospital and each extended care facility. Where these are jointly operated one common committee may suffice.

Seigle W. Parks, M. D., President

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EDITORIALS

IT'S EASY TO POINT A FINGER

Tuberculosis is one of the greatest public health problems in West Virginia. Our State ranks fourth in deaths in the United States. There were 680 newly reported cases for the year 1964. Of the 115 deaths reported during the year, a total of 30 were known for the first time on certificates of death through the Division of Vital Statistics.

The statements in the above paragraph are taken from the Annual Report (1964-65) from the Bureau of Tuberculosis Control, West Virginia Department of Health, and reflects the apathy with which the citizens of our State view this disease. In 1963, the last year for which we have national statistics, West Virginia had a death rate of 8.4 per 100,000 population against a national rate of 4.9. This was not always true. As recently as 1958, our death rate was practically the same as the national rate and all but one of our neighboring states had higher death rates than West Virginia. By 1963 this figure was reversed so that we only had one neighboring state, Kentucky, with a higher death rate and Kentucky has embarked on an all-out campaign of eradication of tuberculosis.

The recent newspaper publicity regarding tuberculosis patients at Weston State Hospital for the mentally ill only will be of value if it draws attention to the whole problem. When West Virginia isolated all mental patients with tuberculosis at one institution, it was hailed as a great step forward. As tuberculosis is very prevalent among mental patients, living under crowded conditions, Weston at one time had more tuberculosis cases than Hopemont or Denmar which then operated as tuberculosis sanatoria. As the period of hospitalization became shorter for people suffering with tuberculosis more sanatorium beds became available and it was suggested that the mental patients with tuberculosis be transferred to Hopemont, in closed wards where needed. It was stated then that this would interfere with psychiatric treatment. Now, with a comparatively few patients having active infectious disease, the problem would not seem near as grave as the press would indicate.

The problem does point out the seemingly complete lack of cooperation between our various governmental agencies. The care of a tuberculous mental patient would seem to be of concern not only to the Department of Health and the Department of Mental Health, but to the Commission of Public Institutions, the Division of Rehabilitation, the Department of Welfare and the local health department. Unless we have coordination and cooperation we will continue with higher mortality than our neighbors. The responsibility does not rest with any one person but with us all. Governors of other states

have appointed advisory commissions on tuberculosis control. Virginia has two excellent full-time physicians coordinating tuberculosis control. Kentucky is studying the problem in depth through the medical school at Lexington. Citizens of other states are willing to appropriate sufficient funds for case finding. Public health authorities have been able to secure needed isolation of patients where citizens have demanded it. It is easy to criticize public officials but we refer you back to paragraph one. In 30 cases dying with tuberculosis in 1964 in West Virginia, physicians did not report the disease until the time of death!

MORE THOUGHTS ON MEDICARE

The readers of this journal are knowledgeable, and should be, of the general provisions contained in Parts A and B, Title 18, of Public Law 89-97. Those segments of the law pertain to Health Insurance and Supplementary Medical Benefits Insurance for the aged.

A majority of our nearly 20 million older citizens have been led to believe that on July 1, 1966, adequate in-hospital beds and services, out-patient diagnostic services, physicians' services in hospital, clinic, home and office, and many other benefits will be readily available. In addition to the increased patient load which naturally will accrue as the program develops, it is reasonable to believe that many prospective patients who now need it will defer applying for health care at their own expense until the law becomes effective for simple economic reasons. This trip down the garden path ended on the day this bill was signed by the President. Since that day, the proponents of the measure have made public disclosure of what they knew long before—the facilities available are notably lacking in quality and quantity.

On the other side of the coin—the supply side—there are some 1,770,000 hospital beds of all classes available in the entire country. A recent community survey showed that on an average day there was a 96 per cent occupancy rate. In a 200-bed hospital, that means eight available beds. If one agrees that older persons have no need for pediatric or obstetrical beds, that leaves an average of five medical and surgical beds to supply the expected increased demand. Hospital beds cannot be created overnight—not even by the miracle men on the Potomac—with bureaucracy and billions of dollars available for creating the Great Society.

They will be faced with the haunting spectre of need to provide much with too little, and we might well expect that the many disappointments engendered by these circumstances may well be blamed upon "the doctors" by many of the misinformed older citizens and by the master minds who have contrived such a program based upon political expediency.

Then there is the matter of extended care facilities, defined by law as an institution or a designated part thereof, which has a transfer agreement with an approved hospital. These separate institutions must qualify as "skilled nursing homes," which as such, must operate under policies determined by physicians and registered professional nurses, and which must have at least one registered nurse employed on a full-time basis. We are informed that of all the nursing homes in West Virginia, only five currently are qualified as skilled nursing homes. Thus, under present statute and regulations, none of the remaining hundreds of nursing home beds will qualify for health care of the aged.

There is another seemingly anachronistic element in PL 89-97. Although the older patient may be admitted to the hospital on July 1, 1966, for a minimum stay of three days needed to qualify him or her for admission to a skilled nursing home, that patient will have to wait another six months before the statutory benefits of extended care facilities become effective on January 1, 1967. There may be valid reasons for this six-month hiatus between the availability of these collateral services, and perhaps Wilbur Cohen, alleged to be one of the master planners on the Potomac, will have an answer ready for those disappointed oldsters who are delayed for months in receiving benefits provided by statute.

As this piece is being written, there is great disappointment on the Potomac because only one-half of the eligible oldsters have applied for the Supplementary Medical Care Benefits, and as of this date, they have recruited Sargent Shriver to help comb the boondocks for applicants for prepaid medical care which, after all, may be unavailable if any sizeable number of physicians decide to forego participation in a federal-controlled system of health care. That smudge you can now visualize on the horizon may be but an early sign of the cloud of confusion and chaos which will darken the skies of human endeavor come next July.

These stormy effects surely will be accentuated by the angry criticism of our younger workers whose Social Security taxes were increased January 1, removing needed cash from the pay envelope to provide alleged benefits for many oldsters who do not need such a dole.

What a preview for Armageddon!

ANOTHER CHAPTER ON POTOMAC POLITICAL OBSTETRICS

On the day this piece is written, the National Blue Cross and Blue Shield Plans executive committees are giving serious joint consideration to the many problems which associate these organizations with the operation of Medicare.

The Blues have adopted the adjective "Complementary" in the nomenclature used in defining the types of voluntary coverage required in filling in the defects under the present law.

Although but 50 per cent of eligible oldsters have so far applied for supplementary medical care benefits under Part B of Title 18, it is hoped that a figure closer to 95 per cent of eligibles will be reached before implementation starts. About 6.5 million citizens over 65 are now covered by the Blues, and possibly some 5 million have some type of commercial coverage, many of them having both Blue and commercial protection.

It was commonly believed that commercial carriers would be in competition with Blue Cross, but on this date there was a formal announcement that Blue Cross has been selected as intermediary under Part A, Title 18 (the basic hospitalization plan). With this announcement of the decision of HEW, Blue Cross is now developing a voluntary complementary program for individual subscribers, with various levels of coverage, which must of course be implemented by the local Blue Cross plans. The coverage for large group Blue Cross plans will be handled by contractural negotiations on a national level between the various employee groups and the carrier. The Blues are encouraging the local plans to provide individual coverage in their respective communities. It is to be desired that the multiple plans in our State can reach a common ground in providing statewide identical coverage for insured individuals.

At present it appears unlikely that very many of the commercial insurance carriers will offer complementary coverage under Part B because of the high costs involved in a $50-deductible in any one calendar year. It must be assumed that the majority of beneficiaries over 65 who are covered under Part B must accept benefits which automatically start at $50 a year, with the cost of 20 per cent co-insurance added thereto. This could result in an unsaleable high premium cost policy.

If we consider the possibility of Blue Cross-Blue Shield combining in the effort, it is believed that local Blue Shield plans will offer some type of complementary coverage with the definite understanding that all proposals must be in accord with different state enabling acts and endorsed by the State Insurance Commissioners. There is yet much doubt as to what extent Blue Shield will be an intermediary under Part B.

Information recently acquired leads to the opinion that the several State Insurance Commissioners will not allow any health insurance coverage which is competitive with Medicare. It is important that we realize the possibility of cancellation of all existing competitive programs.

Now in case the foregoing message is not entirely clear, please be informed that the writer, with clear access to the source of information, is also in a brown study. Your consideration can be compounded by the differentiation between the usual, customary, and prevailing fees involved in this picture.

It all leads up to the conclusion previously stated that chaos and confusion are most apt to occur come next July and the conditions noted in this article are but one facet of this entire picture which will be unveiled this coming summer. The post-natal trials of this unwanted child will surely try the patience and abilities of all parties concerned.

PORTAL HYPERTENSION

In a scientific paper elsewhere in this issue of *The Journal*, Dr. Cornelius E. Sedgwick has given us a concise and stimulating review of the anatomy, physiology and pathology of portal hypertension. We so often thought of only cirrhosis as its etiological factor that our treatment of the portal hypertensive left much to be desired.

Now, with quick reference to Table 1, we see at a glance the pathological entities produced by intraphepatic block, extrahepatic presinusoidal blocks, and extrahepatic postsinusoidal blocks. The clinical workup of these patients is next correlated with its pathology and altered physiology. The ultimate value of each diagnostic procedure is discussed as well as the technical dangers. The Lahey Clinic has continued to favor esophagogastroscopy as the most accurate technique for the rapid differential diagnosis of bleeding peptic ulcer and esophageal varices.

The common sense treatment of portal hypertension is then brilliantly discussed in such a manner that any surgeon will derive the utmost benefit in his own technical approach to that case in his own hospital.

Finally, the divination of the authors regarding portal hypertension is wound up with a discussion of late complications such as recurrent hemorrhage, thrombosis of the shunt, peptic ulceration and portasystemic encephalopathy.

GENERAL NEWS

Dr. B. B. Richmond Named To Head State Medicare Unit

Dr. B. B. Richmond of Beckley has been appointed Medical Director of the new Health Insurance Benefits Unit of the State Health Department.

B. B. Richmond, M. D.

Doctor Richmond's appointment was announced by Gov. Hulett C. Smith at a news conference in December.

The Unit, operating under special agreement with the Secretary of Health, Education and Welfare, was established on November 17, 1965, to carry out activities under Section 1864 of Public Law 89-97 (Medicare). The Unit will be responsible for certification, consultation, and coordination under the new Health Insurance Benefits program.

Certification will consist of determining whether health care facilities meet conditions of participation as outlined in the Social Security Amendments of 1965. Consultation will involve advisory assistance to facilities which may need help to qualify as providers of service under the program.

Another major function of the Unit involves relating the activities of the Unit with those of other agencies involved in implementing and administering the Medicare program.

Institutions which request certification by the new Unit will be surveyed by special teams operating from Charleston. Hospitals, extended care facilities, home health agencies, and independent laboratories are eligible to apply for certification as "providers of service" under the program.

Although workloads prior to the benefit effective dates may prevent immediate scheduling of surveys, all health care facilities requesting certification will be inspected before next May 31.

The Unit recently established offices at 1703 Washington Street, East, in Charleston. Doctor Richmond will be assisted by J. Harry Parker, Director of Administration; and Joseph Lobuts, Richard Kelly and Dillard Mills, Certification Officers.

The staff was drawn from the staffs of the Department of Employment Security and the Division of Vocational Rehabilitation.

Advisory Committee Named

Doctor Richmond also will be assisted by an advisory committee nominated by Dr. Seigle W. Parks, President of the West Virginia State Medical Association, and appointed by Governor Smith.

Dr. Albert C. Esposito of Huntington, Chairman of the Council of the Association, will serve as Chairman of the Advisory Committee.

Other members of the Committee are: Doctor Parks (Ex-Officio); Dr. Richard W. Corbitt of Parkersburg; Dr. Warren D. Elliott of Beckley; Dr. D. E. Greeneltch of Wheeling; Dr. Peter A. Haley of Charleston; Dr. J. C. Huffman of Buckhannon; Dr. Richard V. Lynch, Jr., of Clarksburg, Vice President of the State Medical Association; Dr. Maynard P. Pride of Morgantown; and Dr. W. Hampton St. Clair, Jr., of Bluefield.

Native of West Virginia

A native of Skelton, West Virginia, Doctor Richmond attended Beckley College and the U. S. Military Academy and received his M. D. degree in 1943 from the Medical College of Virginia. He served in the Medical Corps of the U. S. Army, 1944-45. His military assignments included the Department of Anesthesiology and Surgery at Walter Reed Army Hospital and an Army Evacuation Hospital.

He interned at Chesapeake & Ohio Hospital in Huntington and is a Diplomate of the American Board of Urology.

The new Medical Director is a member of the State Medical Association and is a former President of the Raleigh County Medical Society.

Another $500 Contribution To Scholarship Fund

Mr. Harry H. Carnahan, President of The Medical Arts Supply Company in Huntington, has made a contribution of $500 to The Charles Lively Memorial Scholarship Fund of the West Virginia State Medical Association. This is the eighth consecutive year that Mr. Carnahan has contributed the sum of $500 to the Scholarship Fund.

Under the program, 12 students already have been awarded scholarships of $4,000 each to the West Virginia University School of Medicine.

New Association Members

Dr. Robert S. Mutch, 507 Fairmont Avenue, Fairmont (Marion). Doctor Mutch, a native of Philadelphia, was graduated from Temple University and received his M.D. degree in 1947 from Hahnemann Medical College in Philadelphia. He interned at the United States Naval Hospital in Philadelphia, 1947-48, and served residencies at Delaware Hospital in Wilmington and Geisinger Hospital and Foss Clinic in Danville, Pennsylvania. He served as a Lieutenant in the Medical Corps of the United States Navy. His specialty is internal medicine.

* * * *

Dr. Milton E. Nugent, The Wheeling Clinic, Wheeling (Ohio). Doctor Nugent, a native of Glen Ullin, North Dakota, was graduated from the University of North Dakota and received his M.D. degree in 1942 from Rush Medical College. He interned at Youngstown Hospital Association in Ohio, 1942-43, and served residencies at Washington University in St. Louis and Wisconsin General Hospital. He served as a Major in the Medical Corps of the United States Army, 1943-46, and he was previously located in Bismarck, North Dakota. His specialty is ophthalmology.

* * * *

Dr. Frank T. Varney, Box 157, Stone, Kentucky (Mingo). Doctor Varney, a native of Stone, Kentucky, was graduated from Eastern Kentucky State College and received his M.D. degree in 1963 from the University of Louisville School of Medicine. He interned at Floyd Hospital in Rome, Georgia, 1963-64, and he is engaged in general practice.

Pamphlet on Epilepsy

The Epilepsy Foundation is making available to physicians a pamphlet entitled "Quackery's Gray Area."

The publication discusses drugs offered through the mails as treatments for epilepsy.

Copies may be ordered without cost from The Epilepsy Foundation, 1419 H Street, N. W., Washington, D. C. 20005.

Two Retired Grafton Physicians Honored at Reception

Several hundred persons attended a reception in Grafton on December 5 honoring Drs. Paul P. Warden and J. U. Kimble, both of whom retired in recent years.

Both physicians are honorary members of the Taylor County Medical Society and the West Virginia State Medical Association.

Doctor Warden received his M.D. degree from Jefferson Medical College in Philadelphia and practiced medicine in Grafton from 1922 to December, 1963.

A native of Sistersville, Doctor Kimble received his M.D. degree at Maryland Medical College in Baltimore. From 1905 to 1927, he practiced in Newburg. He moved to Grafton and practiced there until his retirement in 1964.

Officers and members of the staff of Grafton City Hospital presented both physicians with gifts at the reception.

New Orleans World Clinical Tour Is Announced

The New Orleans Graduate Medical Assembly will conduct its 29th annual meeting and a worldwide clinical tour in March.

The annual meeting, March 7-10, is acceptable for 29 accredited hours by the American Academy of General Practice. The registration fee is $25.

The clinical tour will begin March 12 with departure from New Orleans aboard Delta Airlines. Participants will attend international clinical meetings in Tokyo, March 15-19, and New Delhi, April 4-8. En route, the party will visit Honolulu, Nikko, Kyoto, Nara, Hong Kong, Bangkok, Agra, Jaipur and Cairo. There will be an optional extension to the Holy Land.

Additional information may be obtained by writing to The New Orleans Graduate Medical Assembly, Room 1528, 1430 Tulane Avenue, New Orleans, Louisiana 70112.

Dr. Seigle W. Parks (center in left picture), President of the West Virginia State Medical Association, was guest of honor at a dinner sponsored by the Parkersburg Academy of Medicine in Parkersburg on January 6. At the left is Dr. Fay Perry Greene, Jr., who was recently installed as President of the Academy. At the right is Dr. Richard W. Corbitt, who was in charge of the entertainment program. In picture at right, Doctor Greene (center) is shown with Dr. E. B. Holmes (left), Immediate Past President of the Academy, and Dr. Dwight P. Cruikshank, President Elect.

Health Department Designated As Certifying Agency

The State Department of Health has been designated by Gov. Hulett C. Smith as the state agency to certify providers of home health services under the Social Security Amendments.

Providers of services may include hospitals, extended care facilities, and home health agencies which meet requirements for certification. According to the report, the term "home health agency" is used to designate a public agency or private organization (or a subdivision of either) which is primarily engaged in providing skilled nursing service and at least one of the following: physical, occupational, or speech therapy; medical social services under the direction of a physician, or parttime or intermittent services of home health aids.

State Health Director N. H. Dyer, in a recent issue of "State of the State's Health," said the agency must have policies established by a group of professional personnel who are associated with the organization, including one or more physicians and one or more registered professional nurses. The program must be under the supervision of a physician or a registered professional nurse and clinical records must be maintained on all patients. The health services are provided on a visit basis, usually at the individual's home.

Under the Hospital Insurance Program, Doctor Dyer explained, enrolled persons may receive up to 100 home visits in the 365 days following discharge from a hospital or extended care facility. Under the Supplementary Medical Insurance Program, which is voluntary and costs enrollees three dollars per month, 100 visits are also allowed during each calendar year with no requirement of prior hospitalization. The patient pays the first $50 for covered services in each calendar year in this program and the program pays 80 per cent of the balance.

Doctor Dyer pointed out some of the benefits that have been demonstrated in areas having home health service programs. They included shorter hospitalization periods and a reduced number of readmissions; care for a number of chronically ill and aged patients who would require institutional care if the home services were not available; and care for many patients who were too ill to go to clinics or doctors' offices, but did not require hospitalization.

A federal matching grant in the amount of $103,300 has been made available in this fiscal year to the State Department of Health to provide assistance in the development of local home health services. According to Doctor Dyer, such grant funds, within budgetary limits, may be made available to local health units or voluntary agencies upon the submission of a suitable program plan. In general, the agencies that are presently nearest to qualifying as providers of services and that serve the largest population will receive first priority.

Members of the State Department of Health staff will be available upon request to give consultative assistance to local organizations desiring to qualify as home health agencies.

In another issue of the "State of the State's Health," Doctor Dyer reported on the Health Referral and Counseling Service for young men in the state medically rejected from military service. Set up in June of 1965 in cooperation with the Public Health Service of the U. S. Department of Health, Education, and Welfare, this service provides referral and counseling service to young men in obtaining proper medical attention.

Doctor Dyer noted that many young men appearing before draft boards are unaware of the reasons for their rejection. He said that they do not understand the importance of seeking care for the physical or psychiatric conditions identified at armed forces examining stations. According to Doctor Dyer, this nationwide project operates on a voluntary basis for the rejectee.

Doctor Dyer commented that the percentage of rejectees who have accepted the services of this project in West Virginia is greater than the national average.

MLB Licenses 18 Physicians To Practice in State

The State Medical Licensing Board licensed 18 physicians, including 17 by reciprocity or by endorsement of credentials, at a meeting held at The Capitol on October 12, 1965. The following physicians were licensed by reciprocity or endorsement of credentials:

Altizer, Tom Joe, Huntington
Branch, James Christian, Huntington
Brandabur, Jos. Hubert, Huntington
Caldwell, Bobby Lee, Charleston
Cohen, Lawrence Sanford, Beckley
Crowgey, Frederick Randle, Salem, Ohio
Dines, George Louis, Steubenville, Ohio
Gruggel, John Stuart, Parkersburg
Hogan, Gwendolyn Rosalie, Morgantown
Jones, Reverdy Hamlin, Jr., Fairmont
Martin, Jas. Douglas, Morgantown
Saferstein, Harold Leonard, Wheeling
Shane, Stanley Roy, Morgantown
Thomas, Kenneth Eastman, Morgantown
Watson, Paul Virgel, Charleston
Weber, Velda Jenecke, Petersburg
Weber, Harry Jackson, Petersburg

Also licensed on October 12 was Dr. Zoltan Szalontay of Wheeling, who had passed the examination previously.

Medicare Booklet Offered

The Continental Casualty Company of Chicago has prepared a booklet entitled "A Simplified Guide to Medicare" for physicians and other interested persons.

The booklet attempts to explain what Medicare will and will not do.

Physicians may obtain copies free of charge by writing to "Medicare Booklet", c/o Continental Casualty Company, Department 13E, 310 Michigan Avenue, Chicago, Illinois.

Ohio Medical Donates $2,500

The Ohio County Medical Society recently contributed $2,500 toward operating expenses at the Russell Nesbitt School in Fulton, Ohio, near Wheeling.

Dr. Martha J. Coyner To Speak At AMA Conference

Dr. Martha J. Coyner of Harrisville has been invited to speak at the AMA Rural Health Conference, which will be held in Colorado Springs, March 18-19.

Doctor Coyner will speak at a dinner meeting of state rural health chairmen on the eve of the conference. She is Chairman of the Rural Health Committee of the West Virginia State Medical Association.

Doctor Coyner will describe for her counterparts the 1965 West Virginia Rural Health Conference, which drew a record attendance of 392 persons.

The meeting in the Broadmoor Hotel is sponsored by the American Medical Association's Council on Rural Health along with state medical associations, farm, educational, and allied health organizations.

Dr. W. Wyan Washburn, of Boiling Springs, North Carolina, Chairman of the Council on Rural Health, described the purposes of the Conference as: to improve methods of communication in health education for rural people; to more fully understand and be able to utilize more efficiently health manpower resources in a community; to assess the effect of environmental factors on the health, safety and well-being of people living in rural areas; and to discover and be able to implement the utilization of community health resources.

Following an address by Gov. John A. Love of Colorado, the sessions on the 18th will feature programs to meet health manpower needs, guidelines for better communication, and water pollution control measures in rural areas. The program for the 19th will be highlighted by breakfast discussion groups on a wide range of health subjects, a talk on rural accident prevention, and a review of the work of the National Commission on Community Health Services.

Marion D. Hanks, LL.B., of the Church of Jesus Christ of Latter-day Saints, will speak on the subject "What Rural Youth Needs Today" at the banquet session on Friday evening in the International Center.

ACP Is Planning Tours For Members

The American College of Physicians is arranging a tour of Bermuda after its 1966 convention in New York.

The ACP meeting begins April 18 and ends April 22. The tour of Bermuda is being arranged for April 23-30 at $323 per person.

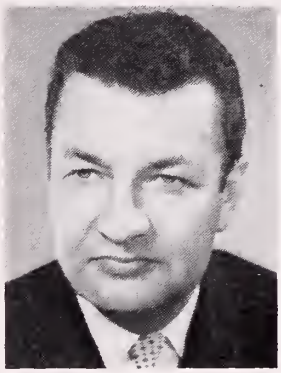
Price includes roundtrip air fare between New York and Bermuda, hotel, meals, tips and entertainment.

ACP also is offering a choice of tours in connection with the 9th Congress of the International Society of Internal Medicine, which will be held in Amsterdam, September 5-10.

Registration forms and additional information about all tours are available from Dr. Edward C. Rosenow, Jr., Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

New Executive Secretary Named By Kanawha Medical Society

Don Crislip of Charleston has assumed duties as part-time Executive Secretary of the Kanawha Medical Society, succeeding Harry Brawley, who became director of the State's Educational Broadcasting Authority.



Don Crislip

Mr. Crislip headed the old West Virginia Industrial and Publicity Commission under former Gov. Cecil H. Underwood. Since 1961, he has been Director of Publications for the West Virginia Education Association and Editor of the West Virginia School Journal, positions he will retain.

A former member of the West Virginia House of Delegates, Mr. Crislip was editor and owner of a weekly newspaper in Richwood for a number of years. He also has taught school and worked as a newsman for United Press International and the Charleston Daily Mail.

He holds an A.B. degree from West Virginia Wesleyan College and is working toward an M.A. degree from West Virginia University.

Mr. Crislip is married and has one daughter.

PG Course in Medical Genetics

The American College of Physicians will conduct a postgraduate course in Medical Genetics at the Johns Hopkins University School of Medicine in Baltimore. February 14-19.

Registration fees are $60 for ACP members and $100 for nonmembers.

Registration forms and additional information may be obtained by writing to Dr. Edward C. Rosenow, Jr., Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

Angiology Meeting in Madrid

The International College of Angiology will conduct its eighth annual meeting in Madrid, Spain, August 31 through September 5, 1966.

Emphasis will be on the clinical aspects of vascular medicine and surgery.

Additional information may be obtained by writing to Dr. H. E. Shaftel, Secretary, International College of Angiology, Inc., 50 Broadway, New York, New York 10004.

Dr. Hale on Chamber Board

Dr. Daniel Hale of Princeton recently was named to a three-year term on the board of directors of the Princeton Chamber of Commerce. The appointment was effective January 1.

Blue Shield Enrollment Up During 1965

Blue Shield enrollment and benefits soared to new highs in 1965.

According to statistics compiled by the National Association of Blue Shield Plans, coordinator of the 85 Blue Shield Plans in the United States, Canada, Puerto Rico, and Jamaica, membership during the first nine months reached 57,286,041—up more than a million over the 1964 year end total.

Benefits paid on behalf of subscribers during the first three quarters were $1,017,491,063, or $89,658,818 over 1964's third quarter and certain to break that year's mark of $1.241,856,467.

Meanwhile, Blue Shield was involved in a wide range of activities resulting from the passage of the Medicare Law.

Following urging by the American Medical Association to "play an important role in administering the Medicare Law," Blue Shield representatives were appointed to serve on work groups established by the Social Security Administration to assist in drafting carrier criteria and regulations for Part B, the Supplemental Medical Insurance Program.

Almost all Blue Shield Plans have signified their interest in serving as carriers and most have resolutions from their local medical societies expressing their preference for Blue Shield.

In addition, virtually all Blue Shield Plans are readying coverage to complement Part B.

In the Federal Employees Health Benefits Program, new figures released by the government during 1965 showed Blue Shield increasing its leadership over its nearest competitor.

Today, some 1,234,000 U. S. Government employees —56.2 per cent—are Blue Shield subscribers.

A new method of prepaying medical surgical bills was initiated by some Blue Shield Plans in 1965.

Called the Prevailing Fees Program, it is a method whereby Blue Shield will provide benefits to its subscribers by paying 100 per cent of the usual and customary charges of the vast majority of physicians.

The program is in effect in five of the 85 Blue Shield Plans and 30 others have the program in various stages of implementation.

John W. Castellucci, Executive Vice President of NABSP, said that under the Prevailing Fees Program, Blue Shield Plans can guarantee to pay the usual charges of at least 90 per cent of physicians.

He said this will enable Blue Shield to meet the demands of major purchasers for paid-in-full benefits without an income test for subscribers, and with predictable costs.

"Experience to date has been good," Castellucci reported, "and we anticipate increased demand and implementation of the Prevailing Fees Program in 1966."

Heart Association Accepting Grant Applications

The West Virginia Heart Association is accepting until April 1 applications for research grants-in-aid from investigators in West Virginia who are working in the cardiovascular field.

The Association said the grants are not restricted to any particular discipline, but the investigator must be qualified and have available the facilities necessary to pursue his investigation. Although no maximum has been set, individual requests should not exceed $3,000.

Grants-in-aid are awarded by the Association to scientists who need interim or supplementary support for on-going projects or who wish to demonstrate by pilot experiments the value of a new project. The grants constitute one phase of the Association's research program, which is supported by public contributions to the annual Heart Fund Campaign held throughout the state in February.

Application forms and additional information may be obtained by writing to Mr. O. D. Wyatt, Executive Director, West Virginia Heart Association, 759 West Washington Street, Charleston, West Virginia 25302.

The West Virginia program is separate from that of the American Heart Association, which also makes grants to scientists in the state. Inquiries about the national program should be addressed to: The Director of Research, American Heart Association, 44 East 23rd Street, New York, New York 10010.

Two State Physicians Will Attend AMA Ethics Congress

Dr. Seigle W. Parks of Charleston, President of the West Virginia State Medical Association, and Dr. Albert C. Esposito of Huntington, Chairman of the Council, will be official representatives of the Association at the AMA's First National Congress on Medical Ethics and Professionalism.

The Congress is scheduled for March 5-6 at the Pick-Congress Hotel in Chicago.

"It is our hope that this Congress will act as a spark that will kindle a resurgence of interest in ethical and disciplinary questions indigenous to medicine," according to Dr. James H. Berge of Seattle, Washington, Chairman of the AMA's Judicial Council.

Other interested physicians are invited to attend. Further information may be obtained by writing to the Judicial Council, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Legal Conference in Chicago

Medical society attorneys will gather in Chicago April 15-16 for a Legal Conference for Medical Society Representatives, which is sponsored by the American Medical Association.

Discussion topics will include the Civil Rights Act, hospital-physician relations, utilization committees, fees and legal problems of medical societies.

AMA Environmental Health Program Announced

The program has been announced for the Third AMA Congress on Environmental Health Problems, which will be held at the Drake Hotel in Chicago, April 4-5.

The keynote address, entitled "Accidents—A Preventable Epidemic," will be delivered by Dr. Norvin C. Kiefer, Chairman of the Medical Advisory Committee of the National Safety Council and Chief Medical Director of the Equitable Life Assurance Society of the United States.

A registration fee of $10 to be paid at time of registration in Chicago only, includes admission, two luncheons, a reception and a copy of the proceedings. The program is acceptable for 12 accredited hours by the American Academy of General Practice.

Additional information may be obtained by writing to the Department of Environmental Health, The American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Non-Profit Group to Open Camp for Asthmatics

Allergy Rehabilitation Foundation, Inc., of Charleston, a non-profit corporation, has announced a tentative June 1966 opening of Bronco Junction, a rehabilitation summer camp for asthmatic children.

The 176-acre camp is located at Red House in Putnam County, 32 miles from Charleston.

The foundation is inviting applications from residents and fellows in allergy, pediatrics and general practice for a two-to-nine-week training program at the camp. The training program is designed to provide practical experience in the rehabilitation of asthmatic patients.

Trainees who will complete residencies or fellowships in the summer of 1966 are invited to apply for the entire camp season. Stipends will be determined individually, and choice of time periods should be stated in the application letter.

Further information may be obtained by writing to Dr. Merle S. Scherr, Medical Director, 805 Atlas Building, Charleston, West Virginia 25301.

PG Course in Angiology

A postgraduate course entitled "Current Concepts in Angiographic Diagnosis" will be conducted by the Cleveland Clinic Educational Foundation in Cleveland, February 16-17.

The fee for the course is $30. Residents and interns will be admitted to the scientific sessions without charge if arrangements are made in advance and if space is available.

Application forms and requests for information may be addressed to Education Secretary, The Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106.

State Hospital Offers Course For Clergymen

An introductory course for clergymen in the pastoral care of the mentally ill is being conducted at Huntington State Hospital.

The program began January 10 and is being conducted each Monday for 12 consecutive weeks. Topics include pastoral interviewing, therapeutic approaches to mental illness, moral development in children, signs of mental illness, religious considerations of the mentally ill, alcoholism, religion and psychology, clergy and the emotionally disturbed and future plans for care of the mentally ill.

The Rev. Harold A. LaParl, chaplain at the hospital, is director of the course.

Lecturers include Dr. Mildred Mitchell-Bateman, Director of the State Department of Mental Health, and other members of her staff and the staff of the hospital.

ACP Schedules Heart Course

The American College of Physicians will sponsor a five-day course entitled "The Big Heart" at the Baylor University College of Medicine in Houston, Texas, March 7-11.

Fees are $60 for members of the ACP and $100 for non members.

Registration forms and additional information may be obtained by writing to Dr. Edward C. Rosenow, Jr., Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

39th Spring Congress Announced By Gill Hospital

The Gill Memorial Eye, Ear and Throat Hospital will conduct its 39th annual Spring Congress in Ophthalmology, Otolaryngology and Allied Specialties in Roanoke, Virginia, April 4-8.

The registration fee is $100 for the entire program, or $50 for one-half of it. Twenty-five dollars will be payable date of registration.

Registration forms and other information may be obtained by writing to Superintendent, Box 1789, Roanoke, Virginia.

Dr. Perry E. Gresham Will Head 1966 Cancer Crusade

Perry E. Gresham, Ph.D., President of Bethany College, will lead the American Cancer Society's 1966 fund-raising crusade in West Virginia.

The appointment of Doctor Gresham was announced by Mrs. D. N. Thomas, President of the West Virginia Division of the Society.

Doctor Gresham held the same assignment last year, when the Society exceeded its goal of $250,000. The Board of Directors has increased the 1966 goal to $265,000.

Charleston BS Seeks Approval As Medicare Carrier

The Charleston Blue Shield Plan has filed application with the U. S. Department of Health, Education and Welfare to be designated intermediary in the implementation of Part B of Public Law 89-97 (Medicare) in West Virginia.

Managers and other officials of the various Blue Shield Plans in the State met with the Blue Cross-Blue Shield Committee of the State Medical Association in Charleston on December 5.

After considerable discussion of the implementation of Part B, the plan managers went into executive session. Later, it was announced that Charleston Blue Shield would file application by December 15, the deadline.

Under the proposal, Charleston would be the control plan with the five other plans in the State serving as participating plans.

Two to a Bed

Two matters of medical interest, one American and the other British, appeared early last August in the *London Daily Telegraph*. The first dealt with the passage, and subsequent signing by President Johnson, of the Medicare bill. The second was concerned with the report of a "delegation of matrons and nurses" who protested to Mr. Robinson, the British Minister of Health, about the ill effects for patients and staff alike which resulted from the current overcrowding of Britain's hospitals.

According to this group "Two patients to a bed is common in Britain's 3,000 State hospitals." The delegation explained that "in many hospitals an out-patient is lodged in an in-patient bed while the latter spends the day sitting in a chair or walking about."

A recent survey by the Royal College of Nursing of 58 hospitals scattered throughout the United Kingdom disclosed that in 32 hospitals "two to a bed" was common practice. All 58 had installed extra beds in their wards. The *Nursing Times*, the College's journal, stated that "the solution to the problem was not simple."

The latter statement is unquestionably true. Seventeen years under the National Health Service has brought British medicine to this sad state and there is every reason to believe it will become worse rather than better. American medicine will doubtless follow the same down-hill course if our politicians continue to adopt the worst rather than the best legislation that originates overseas.

Two to a bed! Perhaps that was one of President Johnson's long range plans when he coined the term "Great Society."—H.J.W., in Virginia Medical Monthly.

Change of Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston, West Virginia 25324.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled for the next year.

1966

Feb. 1-5—Am. Col. of Radiology, Chicago.
Feb. 2-6—Am. Col. of Cardiology, Chicago.
Feb. 3-9—Cong. on Medical Education, Chicago.
Feb. 8-12—Am. Col. of Radiology, Chicago.
Feb. 14-18—Am. Protestant Hosp. Assn., Dallas.
Feb. 21-23—Am. Acad. of Allergy, New York.
Feb. 23—Nat. Multiple Sclerosis Soc., New York.
Feb. 28-March 3—Southeastern Surgical Cong., Atlanta.
March 4-9—Am. Assn. of Pathologists & Bacteriologists, Cleveland.
March 5-6—AMA Cong. on Med. Ethics & Professionalism, Chicago.
March 5-10—Int. Acad. of Path., Cleveland.
March 14-17—ACS Sectional Meeting, Cleveland.
March 18-19—AMA Rural Health Conf., Colorado Springs.
April 13-16—W. Va. Academy Oph. and Otol., White Sulphur Springs.
April 13-16—Am. Radium Soc., Phoenix.
April 14-16—W. Va. Chapter, ACS, The Greenbrier, White Sulphur Springs.
April 15-17—Am. Soc. of Int. Medicine, New York.
April 18-22—ACP, New York.
April 21-23—W. Va. Soc. of Medical Technologists, Martinsburg.
April 25-28—Industrial Med. Assn., Detroit.
April 25-30—Am. Acad. of Neurology, Philadelphia.
April 25-29—Am. Col. of Allergists, Chicago.
April 27-29—Am. Ped. Soc., Inc., Atlantic City.
April 27-May 4—Maryland Med. Soc., Baltimore.
April 29-May 1—W. Va. Chapter, AAGP, Charleston.
May 1-4—American Col. Ob.-Gyn., Chicago.
May 1—Am. Fed. for Clinical Research, Atlantic City.
May 2-5—Am. Col. of Ob.-Gyn., Chicago.
May 9-13—American Psychiatric Assn., Atlantic City.
May 22-27—Ohio State Medical Assn., Cleveland.
May 22-25—National TB Assn., San Francisco.
May 23-25—Am. Thoracic Soc., San Francisco.
May 30-June 1—Am. Ophthalmological Soc., White Sulphur Springs.
May 30-June 2—American Urol. Assn., Chicago.
June 2-4—American Gyn. Soc., Hot Springs, Va.
June 23-27—ACCP, Chicago.
June 24-25—Am. Geriatrics Soc., Chicago.
June 25-26—Am. Diabetes Assn., Chicago.
June 26-30—AMA Annual Meeting, Chicago.
July 7-9—Am. Med. Women's Assn., Rochester, N. Y.
July 10-14—Med. Women's Int. Cong., Rochester, N. Y.
Aug. 25-27—W. Va. State Medical Assn., White Sulphur Springs.
Aug. 29-Sept. 1—Am. Hosp. Assn., Chicago.
Sept. 8-10—Am. Assn. of Ob.-Gyn., Hot Springs, Va.
Sept. 9—Maryland Medical, Ocean City.
Sept. 20-22—Kentucky Medical, Louisville.
Sept. 23-27—Col. of Am. Pathologists, Chicago.
Sept. 23-Oct. 1—Am. Soc. of Clinical Pathologists, Chicago.
Oct. 1-5—Am. Soc. of Anesthesiologists, Philadelphia.
Oct. 10-13—AAGP, Boston.
Oct. 10-14—ACS, San Francisco.
Oct. 16-21—Am. Acad. of Oph. & Otol., White Sulphur Springs.
Oct. 21-23—Am. Heart Assn., New York.
Oct. 22-27—Am. Acad. of Pediatrics, Chicago.
Nov. 6-9—Med. Soc. of Virginia, Williamsburg.
Nov. 14-17—Southern Med. Assn., Washington.
Nov. 26-27—Am. Col. of Chest Physicians, Las Vegas.
Nov. 27-30—AMA Clinical Convention, Las Vegas.

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Autogenous Vein Grafts in Advanced Peripheral Occlusive Arterial Disease*

Charles D. Hershey, M. D., and Edward C. Voss, M. D.

The surgical management of chronic occlusion in the femoropopliteal segment of the arterial tree has been a subject of disagreement since its inception. Failure following surgical intervention has been common, but these failures have resulted in changing concepts and divergent opinions which have benefited this field of surgery.

The "experimental" use of autogenous veins to bridge severed arteries was carried out early in this century by the pioneers in vascular surgery, Carrel and Guthrie. Since then the history of autogenous substitution (notably, the use of veins as bypass) in the treatment of arterial disease has been one of wavering enthusiasm in spite of the early work of Kunlin, Julian, Lord and Dale. More recently it has been prodded on its bullish course by most gratifying results reported by Linton in the early 1960's, so that it is now being accepted as perhaps the most satisfactory approach to a vexing problem.

Our enthusiasm with the use of an autogenous venous conduit to bypass occlusive arterial disease in the periphery continues to increase since its first use in 1962. Initial and long-term patency rates seem to fall into agreement with those of most other proponents of this technique, and this is in sharp contradistinction to those found in prosthetic grafting or endarterectomy.

Living Graft

The autogenous vein graft is a living graft with all three of its anatomic layers preserved. Independent investigators have studied vein grafts implanted as long as 13 months previously and have arrived at similar conclusions. There was a normal gross appearance in all. Some dilatation of these veins takes place, as there was a 50 to 75 per cent increase in the diameter of the graft as compared with that in its original state. The intima remained intact and without evidence of ulceration. The media was only slightly thickened. The most striking change was found in the adventitia, marked by considerable thickening and the presence of numerous and thick elastic fibers. The peri-adventitial tissues were free from inflammatory reaction. The lack of degenerative change was very striking. Changes seldom are found angiographically in vein implants. Szilagyi followed 39 in this manner and only three showed rather minimal irregularity of contour that might be attributable to intimal ulceration and clotting.

In contrast, the problem in endarterectomy is where to call a halt to the dissection. Invariably, thickened intima remains, with resulting narrowing as compared with the endarterectomized segment. A patch graft can be placed at this point but here again this results in even greater disparity. Furthermore, the ragged media—adventitia which remains to line the lumen—predisposes to thrombosis. The principal reason for failure of plastics and homografts is considered to be the foreign body nature of these arterial substitutes. It has been shown that the most common cause of late failures with plastic grafts in this segment has been the concentric laying

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of intraluminal clots in areas in which the velocity of blood flow has diminished. Unfavorable hemodynamic changes are likely to occur in the femoral and popliteal areas, and plastic grafts and endarterectomy do not tolerate these situations well. Although a neo-intima may appear in both plastic prosthesis and in an endarterectomized segment, these conduits do not have a luminal lining that can prevent the formation of surface thrombi at times of diminished blood flow, particularly when a long segment is involved.

Progress reports from an increasing number of centers employing the long saphenous vein as an arterial bypass have shown great improvement when contrasted with other methods of reconstruction. Gutelius, Kreindler and Luke, of Montreal, report 80 cases in which the patient was treated with vein graft or endarterectomy. In spite of the fact that the group subjected to autogenous vein grafts contained a higher percentage of far advanced cases, they found that 80 per cent of this group remained open through a follow-up period averaging 16 months. In the group treated by endarterectomy, only 55 per cent remained open after an average interval of 17 months. Of 60 patients in the autogenous vein graft group, 11 failures occurred during the early postoperative period and there was one late closure, three months after operation. In the endarterectomy group of 20 patients, six occluded in the postoperative period and late closures occurred at four, seven and 11 months postoperatively. In the venous graft group there was little difference in the patency rate in patients operated upon for claudication alone, as compared with those with demonstrable ischemic changes. Twenty-five of 32 patients with claudication remained patent, whereas 23 of 28 patients remained patent in the more advanced disease group. The authors attached particular significance to the finding that this result was not obtained with endarterectomy where the success rate was much lower in those with advanced disease. Diabetes has often been considered a deterrent to femoropopliteal surgery, but the Montreal group has found a minimal difference in patients treated by vein grafts, where they obtained an 84 per cent patency in nondiabetics and 78 per cent in patients suffering from diabetes mellitus. Conversely, where

Figure 4-A Figure 4-B

Figure 4. (A) Typical far advanced disease. Note cadaveric appearance of foot. (B) Appearance of extremity following vein graft.

endarterectomy was employed, this was dramatically reduced to 65 per cent in nondiabetics and the endarterectomy site was occluded in all three diabetic patients.

Linton reported upon 76 consecutive vein grafts performed during the period from 1954 to 1960 with a success rate of 86 per cent. These patients were followed from six months to six years and there were no late occlusions after the two-year period had been passed. None showed evidence of atherosclerotic change nor of excessive dilatation. He has recently reported a larger series with essentially the same results. A most significant conclusion was that the longer the graft remained patent, the less chance there was for late failure, since graft occlusion, after a period of two years, was a rare occurrence. This is in pleasant contrast to most reports of other methods of reconstruction where there is a diminishing incidence of patency as time elapses.

Material

During the past three years, we have performed bypass grafts, using the long saphenous vein, upon 20 extremities. The modest size of

Figure 1
Immediate failure—poor "run-off" distally.

Figure 2
Post-op occlusion. Small thrombus formed distal to anastomosis. Re-operation restored peripheral circulation.

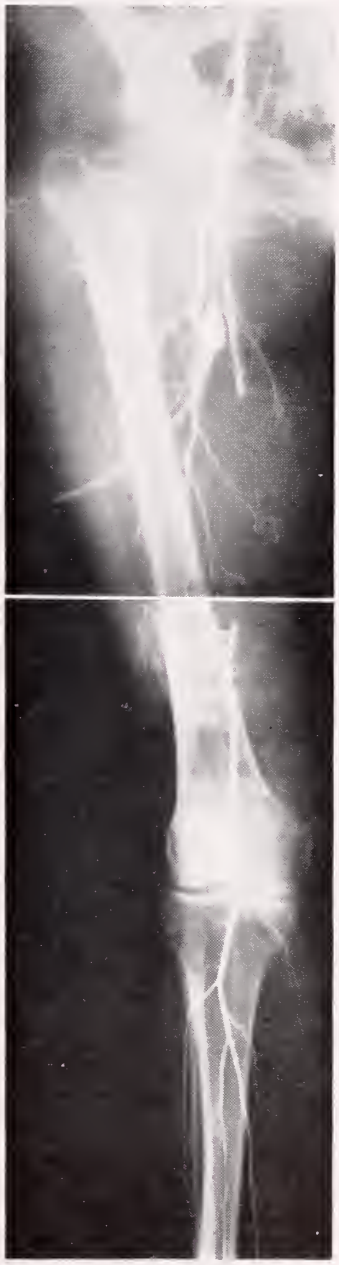

Figure 3
Good operative risk — trifurcation of popliteal with excellent "run-off."

this series is due to the fact that only patients with advanced disease have been considered for surgery. Ten of the patients, or half of the series, had either actual gangrene or marked pregangrenous changes. Five, or 25 per cent, had rest pain and only five complained of claudication alone. In all the latter, however, the claudication was considered to be crippling. These cases have been followed as long as three years with continued patency of the graft and successful outcome of the extremity in 16, or 80 per cent, of the cases. There was but one immediate failure and this terminated in amputation. There were three delayed failures occurring two months, three months and six months postoperatively. The one immediate failure was a desperation effort to save an extremity in spite of an arteriogram showing no pick-up in the popliteal artery (Figure 1). The six months failure was in a 65-year-old diabetic female with pregangrenous change in the great toe. But after occlusion of the graft, the preoperative color change did not recur and her only complaint was claudication. The second late failure occurred three months postoperatively in a 75-year-old diabetic female with a cold, blue foot. Arteriograms showed a rather meager run-off and operation was carried out in an effort to salvage this extremity since amputation had been contemplated. The graft survived three months but, after occlusion, the foot remained viable and greatly improved over its preoperative condition. Sixteen months later the foot appeared in good condition. This phenomenon has been observed by others and is important. A short period of restored circulation in tissues in a reversible stage of degeneration may result in a salvage of the extremity even though the graft occludes. The third delayed failure occurred two months postoperatively and was a result of infection, with hemorrhage from the graft, and eventually terminated in a supracondylar thigh amputation. Thus, major amputation has been necessary in only two of 20 cases with far advanced arterial disease. All patients are still living, with the exception of one who has since died of bronchogenic carcinoma. Our series is most interesting in that eight women were operated upon for this disease, which is one considered to be dominated by the male sex.

These results parallel those of Linton in whose cases less selectivity was employed since his series contained a considerable number of patients complaining of claudication alone. This would be in agreement with the opinion of the Montreal group, that the over-all results were approximately the same whether or not ischemic changes were present. In one respect this is encouraging in that patients with advanced arterial disease can expect a better outcome than has heretofore been possible. From another standpoint, however, it presents a word of caution in selecting patients for operation. If a good run-off is found radiologically, the failure of a vein graft is considered to be due to technical error or postoperative complication. If the patient with minimal symptoms is just as prone to these unfortunate occurrences as the one with far advanced disease, a most careful evaluation of each individual's symptoms and physical findings must be made before advising this operation. Studies carried out over long periods of time have shown that claudication alone does not anticipate the loss of an extremity. We are still maintaining the policy of not performing this operation on patients with mild or moderate degrees of claudication. This conservative view is shared by Szilagyi after many years of experience with this type of surgery.

The technique of bypass grafting is basically that as described by Kunlin and emphasized by Linton. Minor personal variations are added and discarded as becomes convenience. It must be remembered that vein grafting is a more tedious procedure than prosthetic grafting. The one limiting factor in the technique is the availability of a satisfactory vein. We encountered three patients with an inappropriate vein. In one, the greater saphenous vein was found to be thrombosed and a dacron prosthesis was utilized, with a poor result. In the second, the vein was found to divide into two inadequate components and an endarterectomy was resorted to. In the third patient, the vein was too small in caliber and the vein from the opposite thigh was utilized with success. It is felt that four millimeters is the absolute minimum diameter for the vein.

Arteriographic studies are imperative to evaluate the extent of disease and to make a rational attempt at preoperative planning. The RISA scanographic technique as described by Hershey and Howland has been used to evaluate these extremities and may well be expanded to include a "vascular scan" of the entire arterial tree from thoracic aorta on down, as has been utilized by Curry and associates.

Comment

It would be trite to attempt to compare results or make statistical analogies which are the obligations of large series, but it is incumbent upon the surgeon to discuss the facets of his own experience which impress him. Of these events the distinct value of reoperation, prompt and de-

cisive, when necessary, is impressive and rewarding. There was only one initial failure in our series, but this does not mean there were no instances of occlusion of the graft in the immediate postoperative period (Figure 2). Four patients in this group have required one or more reoperative sessions during the first 48 hours. Two have been converted from an early failure to a completely successful outcome, with a functioning graft. One was converted into an asymptomatic, viable extremity, although the graft eventually went on to occlusion six months later. The fourth became a failure two months later due to infection, the bane of vascular surgery.

Radiographically, there should be at least 1 cm. of open distal popliteal artery, with at least one run-off branch if grafting is attempted (Figure 3). Our one initial failure occurred in a patient in whose case this rule was not observed (Figure 1).

Meticulous operative technique must be observed and this is not to be confined to the anastomosis alone. Marking of the course of the vein preoperatively is indicated to avoid unnecessary dissection. Protection of the wound during the operation is essential to avoid infection and sloughing.

We have been particularly impressed with the superiority of autogenous vein grafts in infected limbs as is so frequently found when ulceration or gangrene is present.

Other authors have reported a high incidence of postoperative edema and this series is no exception. The cause of this has not been entirely explained but De Weese and associates feel it is due to thrombosis of the popliteal veins as a result of operative trauma. They have reported a reduction of this complication from almost 100 per cent of their cases to 10 per cent, by the use of low molecular weight dextran.

Summary

1. With the test of time, autogenous vein grafts show promise of becoming the most acceptable surgical attack on atherosclerotic occlusion in the extremities.

2. Autogenous vein grafts are particularly superior in the presence of infection.

3. Meticulous surgical technique is mandatory with this approach and an aggressive attitude is stressed when acute graft failure is encountered, for it is here that reoperation often can be most gratifying.

4. In this series of 20 grafting procedures, there was one immediate failure and three delayed failures.

A list of references may be obtained by writing to The Journal.

Women in White

When doctors more and more take to wearing "business suits" instead of white jackets in their office; when even some orders of nuns permit the sisters to depart from their traditional habit; when Navy nurses and "Visiting" nurses wear blue instead of white; when psychiatric wards experiment with nurses wearing street clothes rather than uniforms—when all this happens, it is too much to expect that hospital nurses will be content with starched white uniforms. For the last four years, the pediatric nurses at the Gainesville (Florida) Clinic have been wearing colored dresses and ordinary ("street") shoes and stockings on duty. Taking a second look at the program, the nurses, their little patients, and the patients' parents (and, one assumes, the interns) are all in favor of expanding the experiment to all parts of the hospital.

The original idea was that white symbolized cleanliness, which—as any driver of a white automobile knows—isn't always so. White is also worn by chefs, street cleaners, and Good Humor men. The theory was that white uniforms had a soothing effect on children and a solacing effect on nervous adults. Experience at Gainesville has shown that this just wasn't true. Children felt more secure with women in conventional dresses. In one statistical survey, it was shown that, while doctors were peering into their ears and mouths, children sat more contentedly on the laps of nurses wearing colored dresses than on the laps of women in white.

Next step: fashion designers stylizing special frocks (not uniforms) for nurses . . . Well, why not? A little color often brings a lot of good cheer.—The Journal of the Medical Society of New Jersey.

The Complications of Myocardial Infarction

P. Benny Cipolloni, Jr., and Robert J. Marshall, M. D.

Over half a million people die annually in the United States alone from myocardial infarction, the majority of them being stricken during the most productive period of their lives. National concern over this death rate is evident from the recent publication of the report of the President's Commission on Heart Disease, Cancer and Stroke, and from the subsequent extensive comment on the report by the various news media.

At the professional level, the attitude towards myocardial infarction has been tinged with a certain amount of pessimism since the mortality rate among patients admitted to hospital has scarcely altered despite the many therapeutic advances of the past 10 to 15 years. This attitude, however, is changing. It is becoming clear, for example, that constant monitoring of cardiovascular function in patients with recent infarction permits immediate recognition of abnormalities that otherwise are likely to escape unnoticed.[2, 3] Prompt treatment of these abnormalities may prevent the onset of lethal complications such as intractable ventricular arrhythmia or irreversible cardiogenic shock.[4, 5]

The time, therefore, seems appropriate to review some of the more important complications of myocardial infarction, with particular attention to their recognition and treatment.

Shock

This is one of the most ominous complications since, in most large series, 60 to 80 per cent of patients who are shocked on admission to hospital, or who subsequently become shocked, succumb. Variations from hospital to hospital in reported mortality rates from cardiogenic shock probably are due more to differences in the criteria for this diagnosis than to differences in treatment. For example, prolonged hypotension sometimes is erroneously equated with shock, even though the patient has a warm skin, quiet respiration and a normal heart rate. It is true that hypotension and shock often go hand in hand, but the terms are not synonymous. Shock is more accurately defined in terms of tissue perfusion than in those of arterial pressure.

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The clinical features of cardiogenic shock are well known to all practicing physicians. The patient is apprehensive and often restless; his skin is white or ashen-grey, cold, and covered with beads of sweat; his pulse rate usually is fast and thready, but may be slow; his arterial pressure is low; and he is oliguric. The main factor responsible for the occurrence of shock is inability of the infarcted left ventricle to maintain an adequate cardiac output; peripheral vasoconstriction is present, but is inadequate to compensate for the decreased output. This situation, however, does not always obtain, and it has been suggested that in some patients factors not directly related to defective myocardial contractility are of prime importance.[6] Arterial hypoxemia has been observed during cardiogenic shock and attributed to shunting of about 25 per cent of the pulmonary blood flow through vessels in the lung that are not accessible for exchange of gas.[7] Reduced tissue perfusion leads to metabolic acidosis which results in a vicious cycle, since metabolic acidosis itself directly depresses myocardial function and lessens the response of the heart to catecholamines.[8]

There is currently heated debate as to whether the administration of vasopressor drugs is beneficial or harmful in the treatment of the various forms of shock. Lillehei and his colleagues,[9] also Nickerson,[10] point out that intensive peripheral vasoconstriction is already present in shock, and that the use of vasoconstrictor drugs will increase the blood pressure only at the expense of a further reduction in tissue perfusion, with a resulting increase in metabolic acidosis. They favor the use of drugs, such as dibenzyline, which have an opposite action, that is, the promotion of vasodilatation. Impressive laboratory data

support their concept, at least as it applies to bacteremic shock. There is as yet no published evidence, however, to suggest that vasodilator drugs favorably affect the outcome in cardiogenic shock and, for the present, the vasoconstrictor drugs continue to be used.

Norepinephrine (Levarterenol, Levophed) and metaraminol (Aramine) are the most commonly used vasopressor drugs. Initial enthusiasm for angiotensin II has waned. Norepinephrine is made up in a concentration of 4-8 mg. in 500 ml. of 5 per cent dextrose solution and given by intravenous drip infusion. It is convenient to monitor the infusion rate by the patient's blood pressure, aiming to maintain the systolic blood pressure around 100 mm. Hg (or 120 mm. Hg. in a patient previously hypertensive). More reliable evidence of its efficacy is the disappearance of the clinical signs of shock and an increase in the output of urine. Care should be taken to avoid extravasation of the drug into the adjacent subcutaneous tissues. Metaraminol has some direct action, but acts mainly by releasing norepinephrine from its tissue stores. Fifty to 100 mg. are dissolved in a liter of 5 per cent dextrose solution and given by intravenous drip infusion. It also may be given by subcutaneous or intramuscular injection in doses of 2 to 10 mg., but this is a less effective method.

Digitalization is of unquestioned value when other complications such as left ventricular failure, congestive heart failure and paroxysmal atrial arrhythmias are present. Its value is less clearly established in cardiogenic shock in the absence of these complications, but it is probably still worthwhile. Lanatoside C (Cedilanid) is given in an initial dose of 1.2 mg. (6 ml.) intravenously, followed by 0.4 mg. every two hours for two doses; maintenance doses of longer-acting preparations such as digoxin are then given orally. Alternatively, 1.0 mg. (2 ml.) digoxin may be given intravenously, followed by 0.5 mg. in 3 hours and subsequently oral doses to complete and maintain the desired effect.

Other long established forms of treatment are invaluable, just as they are in myocardial infarction that is uncomplicated by shock. Morphine sulfate, 15 to 20 mg., relieves pain and anxiety. Oxygen is given my nasal catheter at 6 to 8 liters per minute. If left ventricular failure or congestive heart failure is present, a mercurial or thiazide diuretic is indicated. Adrenocortical steroid drugs have been used, especially in patients refractory to the use of vasopressor drugs, but a recent double blind trial has shown that they do not improve the mortality rate. They are, however, indicated if the infarction is complicated by complete heart block, as we will subsequently point out.

Cardiac Failure

This is more likely to occur in older patients, in those with extensive infarcts, or in those with pre-existing infarction or other forms of myocardial or valvular disease. The presence of left ventricular failure is obvious when the patient suffers from orthopnea, paroxysmal nocturnal dyspnea, persistent cough with frothy white or blood-streaked sputum, moist rales at the bases of both lungs, and gallop rhythm of the protodiastolic or summation type. Pulsus alternans (alternating strong and weak pulse) and Cheyne-Stokes respiration also may occur.

Often, however, the clinical features are more subtle. For example, the patient may complain that he is unable to sleep at night or that he keeps waking up despite the absence of pain and despite sedation. Such nocturnal insomnia often responds dramatically to the use of digitalis and diuretic drugs and to elevation of the head of the bed.

X-ray films of the chest show venous engorgement, fleecy mottling of both hilar regions and, sometimes, Kerley lines (distended transverse lymphatic channels in the costophrenic angles) and basal or interlobar effusions.

Venous congestion may remain confined to the lungs, or else the right ventricle may fail, resulting in systemic venous engorgement (right-sided or congestive heart failure). Again, the clinical features of this complication are well known; they include engorged jugular veins, an enlarged tender liver and peripheral edema. Recognition, however, of right ventricular decompensation before these advanced signs are present is of paramount importance. The most valuable clue is the presence of hepatojugular reflux, that is, an increase in the jugular venous pressure on firm compression of the lower margin of the liver. This test is simplicity itself, it requires only thirty seconds or so to perform, but unfortunately, is all too often forgotten.

Cardiac failure complicating myocardial infarction is treated in precisely the same way as cardiac failure of other etiology. The head end of the bed is raised, oxygen is given by catheter or mask, morphine is injected and digitalization is achieved as rapidly as possible, as indicated under "Shock." The use of diuretic drugs and of a diet with severe restriction of sodium is of equal importance.

Digitalis intoxication must be avoided, with its attendant risks of serious arrhythmias such as heart block, paroxysmal atrial tachycardia with block, and ventricular tachycardia. It is most likely to occur in patients who are having a vigorous diuresis and whose diets are deficient in potassium. Prevention is better than cure, and the administration of potassium salts by mouth and occasional checks of the serum potassium level are indicated.

Arrhythmias

The occurrence of arrhythmias and conduction defects complicating myocardial infarction is related to the following factors:

(a) Increased irritability of ischemic zones.

(b) Release of potassium from injured cells.

(c) Increased levels of catecholamines, endogenous or exogenous, in the blood.

(d) Acidosis resulting from prolonged hypotension.

(e) Excessive doses of digitalis, especially in the presence of hypokalemia.

(f) Functional or anatomical interruption of the bundle of His.

Recent experience with constant monitoring of the electrocardiogram (E.C.G.) in patients with acute myocardial infarction has shown that arrhythmias are much more common than was previously supposed. Admittedly, many are transient. Nevertheless, a transient arrhythmia is not to be ignored but, rather, is to be regarded as a potential harbinger of a more prolonged and serious arrhythmia. Experience from six centers in which the E.C.G. is routinely monitored for periods of 3 days to 2 weeks has been summarized.[3] The incidence of arrhythmia and conduction defects varied from 60 to 95 per cent in the six series; their nature and relative frequency are shown in the table. Precise electrocardiographic identification of arrhythmias is essential before treatment is undertaken.

Supraventricular Tachyarrhythmias.—Prompt treatment is essential; otherwise shock or left ventricular failure are likely to supervene. Paroxysmal tachycardia often will cease following strong vagal stimulation; such procedures as carotid sinus massage, strong supra-orbital pressure, or performance of the Valsalva maneuver are worth a trial. Intravenous infusion of a pressor drug such as aramine in order to raise the arterial pressure and reflexly slow the heart is inadvisable in patients with recent infarction because of the sudden pressure load on the left ventricle. Rapid digitalization by the intravenous route is indicated if vagal stimulation is ineffective; it is also indicated for the management of paroxysmal flutter and fibrillation. If the arrhythmia does not end soon thereafter, direct current (D. C.) shock should be employed for flutter and fibrillation; D. C. shock is preferable to waiting for a trial of quinidine. Although D. C. shock has been used without anesthesia, it is emotionally disturbing to the patient at the best of times, and a greater amount of current is needed. Therefore, unless the situation is very urgent, the shock should be applied under anesthesia, with the patient adequately oxygenated.

TABLE 1

Nature and Frequency of Arrhythmias and Conduction Defects Complicating Acute Myocardial Infarction

Supraventricular tachyarrhythmias	
Atrial or supraventricular tachycardia	19
Atrial flutter	6
Atrial fibrillation	61
Ventricular tachyarrhythmias	
Multiple premature systoles	168*
Ventricular tachycardia	64
Ventricular fibrillation	30
Ventricular asystole	21
Conduction defects	
First or second degree heart block	56
Complete heart block	20
Bundle branch block	60
Total number of patients	562

*This figure is an underestimate since, in the largest of the six series, multiple premature systoles were not included as arrhythmias.

Ventricular Tachyarrhythmias.—When there are occasional premature systoles, no specific treatment is indicated, but the patient should be under careful supervision. For multiple premature systoles, an attempt at suppression by intravenous procaine amide is worth while; since this drug may cause hypotension, small doses should be used and the arterial pressure should be measured frequently. New drugs are being developed which suppress adrenergic nervous activity in the heart, and show promise for the control of ventricular arrhythmias; however, they are not yet released for general use.

For ventricular tachycardia and ventricular fibrillation, two highly ominous arrhythmias, immediate use should be made of the D. C. defibrillator. If a defibrillator is not immediately available, and if spontaneous circulation is inadequate precordial massage is undertaken using the technique of Kouwenhoven *et al.*[12] A firm surface under the patient is essential; either a bed board is placed beneath the mattress or the patient is transferred to the floor. The adequacy of precordial massage is gauged by feeling the femoral pulses and noting the color of the skin

and the diameter of the pupils. Excessively vigorous massage must be avoided because of the dangers of fracturing the sternum and ribs and of rupturing abdominal viscera.

Failure of electrical defibrillation to restore sinus rhythm may be due to the presence of hypoxia or acidosis. As massage continues, a second person aids ventilation. A cuffed endotracheal tube is the most effective method of providing oxygen to the lungs and reduces the risk of aspirating gastric contents. In an emergency, however, mouth-to-mouth breathing is better than nothing. Metabolic acidosis occurs rapidly when the circulation stops or is ineffective and contributes to myocardial depression. To combat it, 100 to 200 mEq. sodium bicarbonate is rapidly given intravenously. A solution containing 1 mEq. per ml. is suitable. Alternatively, the buffering agent tromethamine (THAM) may be used if it is advisable (Thrower *et al.* 1961). Procaine amide in large intravenous doses also has been reported to aid defibrillation.[13]

Ventricular Asystole.—The initial treatment comprises closed chest cardiac massage, adequate ventilation of the lungs and intravenous injection of sodium bicarbonate and calcium gluconate. Isoproterenol 0.2 mg. or epinephrine 0.5 mg. may be tried by intravenous or, as a last resort intracardiac injection. Experience with either external or internal (using an electrode catheter) pacemaking has been unrewarding; the ventricles respond electrically to the stimulus, but mechanical contraction is generally inadequate. The reason is that asystole usually if not always occurs as a complication of massive infarction.

Conduction Defects.—In second degree or third degree ("complete") heart block the ventricular rate often is less than 40 per minute; while this slow rate is tolerated reasonably well at rest by many patients who have had no recent myocardial damage, it is tolerated poorly when it complicates a recent myocardial infarct. Before modern drugs and electronic pacing devices became available, the mortality rate was very high, between 40 and 100 per cent in various reported series.[14]

Isoproterenol occasionally increases the heart rate, but usually has little or no effect in older age groups; further, it provides no protection against the possibility of Stokes-Adams attacks due to ventricular asystole. Corticosteroid drugs sometimes terminate the block, especially when given intravenously.[15] The recent success, however, of endocardial stimulation of the right ventricle via an electrode catheter makes this the treatment of choice. Bruce *et al.*[16] reported that eight of nine patients survived following temporary pacemaking; seven spontaneously reverted to normal conduction after two to six days, while the eighth had a permanent pacemaker implanted subsequently.

Myocardial Rupture

Rupture of the free wall of the ventricle or of the interventricular septum is an unusual complication. The former circumstance leads to pericardial tamponade. It may be suspected when there is sudden cessation of effective circulation if, instead of the serious ventricular arrhythmia or asystole which one would expect to see, the electrocardiogram shows sinus rhythm with normal intraventricular conduction.

It is most likely to occur late in the first week following the infarct. The prognosis is, of course, very poor, although limited survival has been reported following early recognition and surgical repair of a rupture.

Rupture of the septum is heralded by the sudden onset of congestive heart failure and by the appearance of a precordial regurgitant systolic murmur similar in location and acoustic characteristics to that of congenital ventricular septal defect. If the patient can be tided over until the area of infarction has healed, surgical repair using cardiopulmonary bypass is possible, albeit at a high risk.

Papillary Muscle Dysfunction

Normal function of the mitral valve is dependent upon the structural integrity of the anterior and posterior papillary muscles. Sometimes these undergo infarction. If the infarcted muscle ruptures, there is a sudden onset of severe mitral valve regurgitation, with a loud pansystolic murmur at the apex; the patient may die suddenly or he may survive for a few days or weeks. Prolonged survival is exceptional. Therefore, the possibility of performing a surgical reparative procedure is remote.

More commonly, the papillary muscle does not rupture, but functions inadequately because of loss of its contractility. Some such patients are prone to develop congestive failure although others are not notably handicapped even years after the episode of infarction. The diagnosis should be suspected if (a) a diamond-shaped "ejection" systolic murmur of late onset appears in a patient who has had a previous infarct, or (b) certain changes occur in the electrocardiogram. These changes consist of depression of the J junction and of the ST segment, which is either

concave or convex upwards, in the anterolateral precordial leads.[17]

Left Ventricular Aneurysm

Saccular dilatation of the wall of the left ventricle (left ventricular aneurysm) has always been associated with a poor prognosis. Thus Schlichter *et al.* [18] found that 73 per cent of patients died within three years, and 88 per cent within five years of the time at which the diagnosis was made. This unfavorable situation is no doubt partly due to the fact that aneurysms are most likely to occur in cases in which the area of infarction and subsequent scarring is unusually extensive; it is also partly due to the frequent formation of mural thrombus and the likelihood of systemic embolism, to the impaired cardiac dynamics resulting from paradoxical movement of the aneurysm, and to the risk of rupture.

Left ventricular aneurysm may be suspected from x-ray films of the heart; characteristically, there is a rounded swelling of the high lateral portion of the left ventricle seen best in the postero-anterior view. Confirmation should be obtained by noting the paradoxical movement of its wall at fluoroscopy. If, however, there is a thick lining of laminated thrombus, the aneurysm may be almost motionless. The electrocardiogram is of value in that it shows persistent elevation of the ST segment in the left precordial leads.

The advent of corrective surgery has improved the outlook. There were 29 survivors (78 per cent) of 37 patients who had the aneurysm excised by Cooley *et al.* [19] under cardiopulmonary bypass; of these, 24 were alive two years later. Postoperative cardiac catheterization has documented the improvement in cardiac dynamics.[19, 20]

Thromboembolism

The propensity of patients with recent infarction to develop thromboembolic complications is the reason for the use of anticoagulant drugs. Although there are several theoretical advantages stemming from their use, the effect on the mortality rate is marginal. Indeed, there is still heated debate between those who favor their use[21] and those who do not.[22] Their chief value would appear to lie in the prevention of venous thrombosis and its sequel, pulmonary embolism. It is impossible to say whether they have any value in preventing further thrombus formation in diseased arteries or on the endocardium underlying the infarct (mural thrombus). It is almost trite to state that the possible benefits of anticoagulation always must be weighed against its risks. Thus, access to a reliable laboratory for measurement of thrombotest or prothrombin time is essential; otherwise, the patient is safer without anticoagulant drugs. Evidence for any benefit from long-term prophylactic treatment is even more tenuous.

A list of references may be obtained by writing to The Journal.

What's In A Drug Name?

A FEW YEARS ago nomenclature purists insisted that drugs be named to indicate their chemical structure. We refer to corticosteroids, thiazide diuretics, sympathetic amines, anticholinergics, phenothiazines and anticoagulants but we resort to a contrived word to identify the particular drug we want. We know drugs more by their actions than by their precise chemical structures, which, after all, is the essential information.

By analogy, if we know how to operate a motor vehicle competently, it isn't really very important whether or not we know the dimension of the cylinders, its compression ratio or the mechanism of the automatic transmission.—Theodore G. Klumpp, M.D., in *GP.*

Gas Gangrene — Prophylaxis and Treatment

Robert L. Bradley, M. D., James P. Carey, M. D., and Elizabeth J. Bradley, B. S.

CLOSTRIDIA are ubiquitous.[1] They can be cultured from the soil and are normal inhabitants of the gastrointestinal tract after the first few weeks of life.[13] Animals are passive carriers of the gas producing anaerobes as well as those of tetanus and botulism.[14] Because of this universality, gas gangrene always has accompanied war. It is an infrequent, though potential, complication of all trauma and surgery in civil life.

A disease of antiquity, it was described possibly by Hippocrates[7] in a discussion of a fulminating foot infection terminating in death within 48 hours. Clinical gas gangrene was described vividly by Hildanus[10] in 1607 and was noted in the histories of the Napoleonic wars. The common gangrene of the Civil War was hospital gangrene, though Jones[9] reports a case of typical clostridial myositis.

Clostridium welchii, clostridium oedematiens and clostridium septique are the principal bacteria involved in the production of gas gangrene with clostridium welchii predominating. Clostridium septique (vibrion septique) was isolated by Pasteur and Joubert[12] in 1877. Welch and Nuttal,[17] in 1892, isolated clostridium welchii (bacillus aerogenus capsulatus) from autopsy material of a classical case. Fraenkel,[6] a year later, described a gas producing organism which was proved by Welch to be identical with clostridium welchii. Novy,[11] in 1894, isolated clostridium oedematiens (clostridium novyi). In the Shattuck Lecture[16] in 1900, Welch reviewed the already extensive literature on the subject.

Fauntleroy,[5] in 1915, in his report on the Medico-Military Aspects of the European War, devoted 23 pages of his 146-page report to gas gangrene. He describes the disease in one hospital as follows: "Gas gangrene was apparently as prevalent as in other base hospitals having an active surgical service. This condition was treated here by wide incisions and free drainage, with after-irrigations of helf-strength peroxide of hydrogen, and weak aqueous solutions either of iodine or sodium hypochlorite. Although there were quite a number of stump cases visible, the statement was made that amputation was seldom resorted to in the uncomplicated gas-infection cases, and that the present treatment was eminently satisfactory."

Submitted to the Publication Committee, August 4, 1965.

The Authors

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In World War I, estimates of gas gangrene in wounds were as high as 10 per cent.[4] The principle of primary debridement and delayed closure of wounds, begun in World War I, became dictum in the Second World War. Immediately, a dramatic lowering of the incidence of all infections was noted, including those of gas gangrene. Howard[8] reported a gas gangrene rate of 1.5 per cent in 4,600 casualties with a case mortality of 31.3 per cent.

The World War II principles of wound care were observed in Korea. To this were added immediate evacuation and routine penicillin. Combined, these reduced the incidence of gas infections to a negligible point. Howard[8] in 4,900 Korean War casualties, reported four cases, or .08 per cent, and no deaths.

Gas gangrene continues to occur in civil life. Four cases are reported. Two represent violations of the principle of debridement and secondary closure of contaminated wounds. The other two are rare occurrences of gas gangrene from contamination at surgery.

Case Reports

Case 1. A 19-year-old serviceman sustained a laceration of the left thigh and knee in an automobile accident on September 15, 1951, at approximately 4 A. M. The lacerations were sutured in a physician's office. On admission to this hospital, at approximately 8 P. M. on the same date, physical examination revealed a 7½″ longitudinal, sutured laceration on the lateral

aspect of the left thigh and extending on to the knee. The thigh was markedly swollen with crepitation throughout. The leukocyte count was 23,050 with 89 per cent neutrophiles. X-ray films of the lower end of the femur revealed a moderate amount of gas in the soft tissues. At 9:45 P. M. the wounds of the thigh were re-opened. A moderate amount of necrotic, discolored muscle was encountered and excised. Air was palpable in the affected muscle. Dissection was carried bluntly, with the finger, to the extent of the edema. The wound extended to the periosteum and into the knee joint. Cultures revealed C. welchii. Irrigation with saline and hydrogen peroxide was thorough. Catheters were sutured into the wound. It was packed open and the patient returned to his room with a continuous hydrogen peroxide drip. Penicillin, 300,000 units every three hours, and streptomycin, ½ gm. twice daily, for one week, were administered. Catheters and drains were removed on the third postoperative day and thereafter the wound was irrigated until it had healed secondarily. The patient was asymptomatic, except for his granulating wound, 24 hours postoperatively.

Case 2. A routine cholecystectomy for chronic cholecystitis with multiple calculi was performed on a 47-year-old white male on January 25, 1963. At surgery, the gallbladder was torn, with spillage of bile but no other difficulties were encountered. On the third postoperative day, the patient developed a temperature of 103 F. believed due to atelectasis. Penicillin, 600,000 units b.i.d. and streptomycin ½ gm. b.i.d. for three days were started. (Oral feedings were initiated on the fourth postoperative day). The patient continued a febrile course but otherwise felt well. Examination of the abdomen on February 1, 1963, revealed crepitation to the right of the wound. It was opened and a moderate amount of purulent material escaped along with considerable gas. Culture revealed clostridium welchii. On February 2, 1963, further debridement of the wound was carried out, with raising of the wound flap, and two catheters were implanted. Penrose drains were utilized to keep the skin flaps apart. Continuous irrigation with saline and hydrogen peroxide was initiated. Penicillin dosage was increased to 1,000,000 every three hours for two days. On February 3, 1963, the patient was afebrile. The infection subsided and on February 5, 1963, the catheters were removed. Convalescence was uneventful.

Case 3. At 4:40 P. M. on the day of admission a 45-year-old white male underwent a laparotomy for relief of mechanical obstruction. After re-

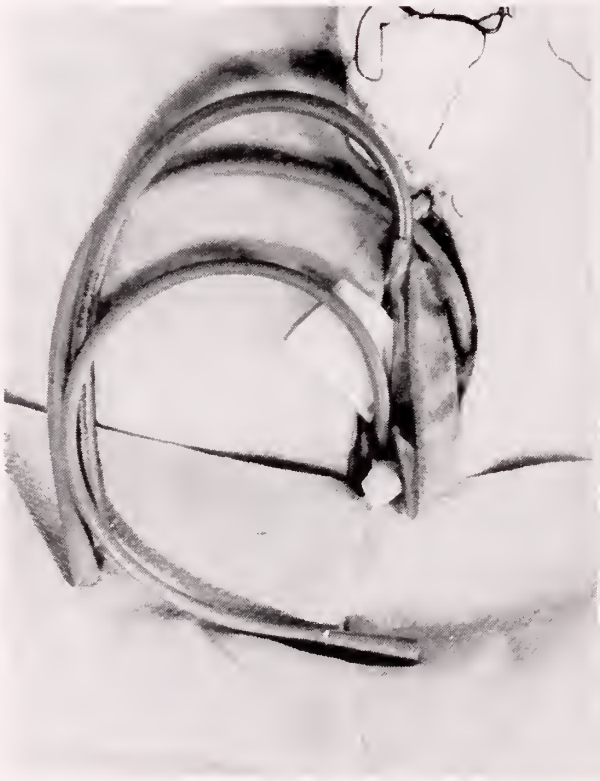

Figure 1

Figure 2

Figure 1. Laparotomy wound reopened with catheters for irrigation in place. (Figure 2) Continuous drip of half-strength hydrogen peroxide and saline.

leasing the adhesions, difficulty encountered in closing the abdomen necessitated deflating the dilated proximal bowel with a trocar. Twelve hours postoperatively the patient developed a fever of 101 F. Minimal atelectasis was found. Thirty-six hours after surgery the temperature reached 106 F. The patient's retention sutures were removed to permit inspection of the wound. Reddish-brown induration at the lower angle was noted and gas could be palpated beneath the skin. The lower angle of the wound was separated with a clamp and a moderate amount of thin, brownish exudate, with gas, was released. Smear and culture revealed clostridium welchii. The patient was placed on penicillin, 400,000 units t.i.d. The following morning, under general anesthesia, the lower end of the wound was extended to the length of the induration and to the peritoneum. Using finger dissection, the planes of edema were followed to their limits at the anterior iliac spines and the suprapubic space. Urethral catheters were placed in these spaces and the wound packed open (Figures 1, 2 and 3). A continuous drip of half-strength hydrogen peroxide was begun. Twenty-four hours after this drainage procedure, the temperature had returned to 99 F (Figure 4). The patient was basically asymptomatic. Catheters were removed 72 hours later. Antibiotics were discontinued after five days. The wound was allowed to heal secondarily.

Figure 3. Wound eight weeks postoperatively.

Case 4. A 61-year-old white male was admitted on November 17, 1961, as an emergency with a shotgun wound of the anterolateral aspect of the left thigh. The wound of entrance measured 2 to 3 centimeters in diameter. It was 5 centimeters distal to the inguinal crease and there was no exit wound. No major vessel or nerve was injured. X-ray films revealed innumerable metallic shot scattered through the soft tissues of the thigh from the level of the greater trochanter distalward for 22 centimeters. There was no fracture.

Immediate debridement and irrigation were performed. The fascia and subcutaneous tissues were approximated with catgut and the skin with silk. Twenty-four hours postoperatively, the patient began a febrile course with temperature elevation to 103 F. Examination of the wound revealed redness and swelling. Tetracyclines were administered. The patient remained septic and on November 20 crepitation was noted about the wound. Reexploration was performed through a longitudinal incision 12 centimeters in length. The entire area was explored and major portions of the vastus lateralis were necrotic and crepitant. All involved muscle was excised. Metallic shot and shell wadding found in the wound were removed. Culture of the exudate revealed clostridium welchii. The wound was loosely packed open. The patient continued a septic course and on November 24 additional necrotic muscle at the extremes of the wound

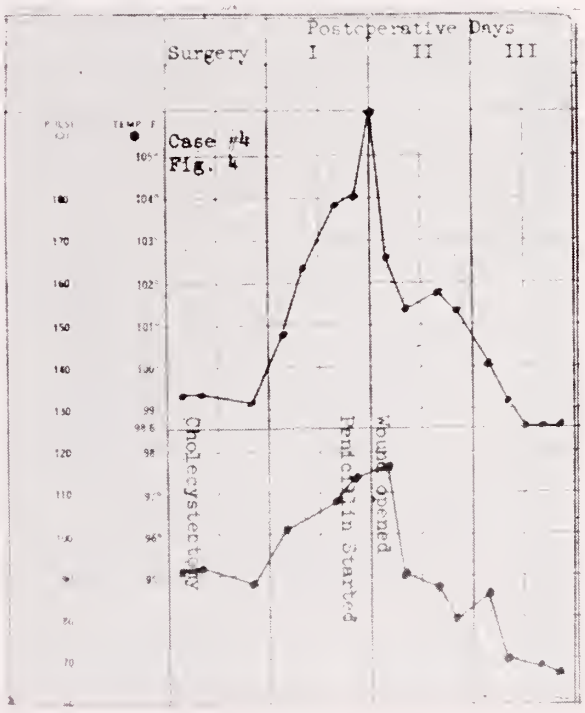

Figure 4.

was excised. Hydrogen peroxide irrigations were begun. The tetracyclines were discontinued and penicillin was started. Convalescence was uneventful.

Summary

Rare is the wound in which clostridial infection develops, though most wounds of trauma are contaminated. Proper debridement will virtually eliminate the disease. Major destructive wounds (Case 1) must be debrided and, if grossly contaminated, secondarily closed. In civil diseases, these two principles of wound care must go into effect if mass infections of all types are to be avoided.

Gas gangrene can complicate surgery. Though rare, it may follow procedures that permit contamination from the gastrointestinal tract (Cases 2 and 3). The clinical symptoms are manifest in 24 to 72 hours. A rapidly progressive, violent toxicity for which no obvious cause can be found, impels exploration of the wound. The presence of gas and necrotic tissue warrants a clinical diagnosis; culture of clostridia establishes it.

Routine penicillin may mask the disease, but will not eradicate it. Control by crisis was obtained in the patients with abdominal wall infection when the wound was opened to the peritoneum with blunt dissection lateral to the extent of the spread (Figure 4). Penicillin and irrigation completed the regimen.

Gunshot wounds of the soft tissues must never be closed, primarily. Violation of this principle will lead to catastrophe (Case 4).

Debridement and delayed closure will prevent clostridial infections. Debridement, penicillin and irrigation are effective therapy. Gas gangrene antitoxin is not needed.

Of paramount interest are the reports of Boerema[2] et al., Brummelkamp[3] et al. and Wallyn[15] et al, concerning the treatment of gas gangrene and other anaerobic infections with hyperbaric oxygen. For those patients with anaerobic infection not amenable to debridement and irrigation, the therapeutic addendum will merit evaluation.

A list of references may be obtained by writing to The Journal.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

99TH ANNUAL MEETING

of the

West Virginia State Medical Association

The Greenbrier

AUGUST 25-27, 1966

Plan to Attend — Make Your Reservation . . . Now !

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Gastroenteritis

Spastic bowel

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Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

1. Janssen, P. A. J., and Jageneau, A. H.: A New Series of Potent Analgesics: Dextro 2:2-Diphenyl-3-Methyl-4-Morpholinobutyrylpyrrolidine and Related Amides. Part 1: Chemical Structure and Pharmacological Activity, J. Pharm. Pharmacol. *9*:381-400 (June) 1957.

2. Demeulenaere, L.: Action du R 1132 sur le transit gastro-intestinal, Acta Gastroent. Belg. *21*:674-680 (Sept.-Oct.) 1958.

SEARLE

Research in the Service of Medicine

The President's Page

COUNTY SOCIETY OFFICERS WORKSHOP

As a service to the county medical societies, the West Virginia State Medical Association, after recognizing the need for closer association and cooperation, has set Sunday, March 13, for a County Medical Society Officers Workshop.

Although the invitation has been extended to all officers of each county medical society, it is to be stressed that all interested physicians are cordially invited to attend. Certainly the success of this initial meeting will depend largely upon the universal interest and representation from all areas of the State and each county medical society.

It is well known and accepted by many medical organizations that one of the most effective communication procedures is where you can get together the leaders of the component societies and give them a free opportunity to express themselves. This point we would like to make exceedingly clear—this is your meeting, planned with the county medical societies in mind, and will be as successful as you wish to make it.

We are honored to announce that Charles L. Hudson, M. D., President Elect of the American Medical Association, will be our keynote speaker to open our program at 9:30 A. M. on Sunday, March 13, 1966. The topic he has chosen is "Closer Cooperation Among County and State Medical Societies and the AMA." It is most appropriate and will set the theme for this initial Medical Society Officers Conference which we hope will create a demand for similar meetings in the future.

Full details of the program will be released by Mr. Lively through the various publications and mailings. In general, the morning program will consist of the keynote address by Doctor Hudson and several brief 10-minute reports by the chairmen of our key committees.

The theme of the afternoon session will be "Current Challenges to Medicine" and will be presented in panel form. The subjects to be covered will include, "Implementation of the Medicare Law—Both Title XVIII and Title XIX," discussion of utilization review committees and medical education on the undergraduate, graduate and postgraduate levels.

Mark your calendars now. Plan to attend. Show us by your interest that you approve of this type of meeting and desire further meetings in the future.

Seigle W. Parks, M. D., President

THE WEST VIRGINA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

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EDITORIALS

MORE DOLLARS AND LESS SENSE

The incorporators of the Great Society will be either commended or condemned for their diligence in discovering new ways of spending your hard-earned tax dollars. The latest evidence of boondoggling is contained in a press release from Palm Beach County, Florida, and will no doubt be pertinent in hundreds of communities nationwide.

On January 26, the Office of Economic Opportunity approved a grant of $23,281 to the Community Action Committee of Palm Beach County. These funds are to be expended in the employment of 30 paid workers, who with volunteers will comb the boondocks, backwoods, farms and urban areas of the county in an effort to sign up some 2,500 recalcitrant or unknowing oldsters for the benefits of prepaid supplementary medical care under Part B of the Medicare Act. This works out to about $10 a head for this group of prospects. It might be suggested that Sargent Shriver, the boss of OEO, will canvass the Gold Coast of Palm Beach County in person, inasmuch as he already has an entree to this exclusive area through his wife's relatives, who reside therein.

It might be of further interest to our more frugal-minded readers to figure the costs of extending this canvass to the thousands of counties in the nation. It could cost millions of your tax dollars just to provide a larger clientele for your professional ministrations when chaos and confusion begin their reign next July. One cannot help but muse upon the possibility of an executive order to turn out all the lights from the Potomac to the Perdenales in an earnest effort to counterbalance this item in the budget for operating the Great Society.

MENTAL FUNCTIONING FOLLOWING CARDIOVASCULAR AND CEREBROVASCULAR DISEASE

Unfortunately, mental functioning may at times be impaired following cerebrovascular or cardiovascular disease. Both of these conditions are, of course, generally associated with atherosclerosis. Reports have been made that mental functioning in patients who have suffered myocardial infarction or cerebral thrombosis showed improvement following the administration of a conjugated equine estrogen (Premarin).

Caldwell and Watson[2] in 1952 reported improved intellectual functioning in aged women treated with estrogens. However, Lifshitz and Kline[3] in 1961 observed no difference between estrogen and placebo-treated men suffering from a psychosis associated with cerebral atherosclerosis. Furthermore, Pauker et al.[4] in 1958 could observe no improvement in post-therapy psychological evaluation between patients treated with androgens, estrogens and control patients.

It appears, therefore, that the beneficial results from the administration of Premarin in conditions of atherosclerosis are controversial.

Recently Evans and Marmorston[1] reported a study on mental functioning and Premarin therapy in cardiovascular and cerebrovascular disease. Studies were made on 77 male patients, 45 of whom had recovered from an acute myocardial infarction and 32 who had suffered a cerebral thrombosis. Sixteen cerebral patients were given Premarin and an equal number placebo-treated. The average age of the patients in these groups was 59 and 60 years respectively. Premarin was administered to 34 cardiac patients and 11 were placebo-treated; the average age of these groups was 58 and 54 years respectively. Premarin was administered orally in doses of 1.25 mg daily to the cerebral patients and 0.625 or 1.25 mg daily to the cardiac patients. The Rorschach ink blot test was administered at the time either Premarin or placebo-treatment was begun. The test was repeated after 6 to 16 months.

It was observed that following Premarin administration there was improved mental functioning in patients who had suffered from cerebral thrombosis compared with placebo-treated controls. No improvement was found following Premarin administration (doses of 0.625 mg daily) in those who had suffered an acute myocardial infarction. A group which had received higher doses of Premarin (1.25 mg daily) did show some improvement which, however, was not statistically significant. It was also observed that there was a positive relationship between the degree of initial impairment and amount of impairment with Premarin.

Studies such as those reported by Evans and Marmorston are of distinct interest. Any therapeutic preparation or agent which is helpful in restoring mental functioning following cardiovascular or cerebrovascular disease deserves our respectful consideration. Although it is difficult to obtain objective proof when studying changes in mental functioning, it is generally conceded that the Rorschach ink blot test, when properly interpreted, is thought to be a sensitive indicator of mental improvement accompanying organic damage to the brain. However, some psychologists probably would insist that more than one test be used to assess mental conditions. Indeed, a whole battery of tests would presumably give more convincing results.

It is to be hoped that further studies will be made on mental functioning following injury to the brain, and that even more promising agents will be found which will produce significant improvement.

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2. Caldwell, B. M., and Watson, R. I.: J. Geront., 7: 228, 1952.
3. Lifshitz, K., and Kline, M. S., J. Am. Med. Assoc., 176: 501, 1961.
4. Pauker, J. D., et al.: J. Geront., 13: 389, 1958.

NEW MEDICAL SCHOOLS PLANNED

A recent report of the Council on Medical Education of the AMA contains the welcome information that 14 new medical schools are in the process of planning or development. Twelve of the 14 schools will have a four-year curriculum and two schools are for medical basic science subjects. In addition to the above, 30 other colleges have expressed serious interest in a medical project and at least 10 are good probabilities to follow through. This marked increase in planning and construction is due to the fact that the Health Education Assistance Amendment provides funds for construction of medical schools, student loans and other health facilities.

Within the next decade the USA should have more than 100 four-year schools in full operation. The additional schools will provide medical education for more than 1,000 applicants and will keep pace with the estimated increases in population, so that the present ratios of physician to population should be easily maintained.

The report of the Council also shows increasing federal financial support to medical schools through research grants. The statement is made that "at the present rate in the foreseeable future more than half of the full time faculty will soon depend on part or all their salary to come from federal grants."

The increasing number of physicians might indicate that more doctors will be available for community demands in West Virginia and throughout the country. It is probable, however, that the present trend will continue and Administration, Teaching, Research, and Public Health will show an increasing number of graduates interested in these and other non-clinical deviations. It is also probable that sharper division of specialty medicine will attract more graduates. For sure, the Department of Defense will need more physicians and for longer service.

So, barring abrupt changes in traditional methods of medical practice and medical teaching, it seems that the demand for family doctors and general practitioners will continue with increasing cadence.

GENERAL NEWS

Dr. Charles L. Hudson Honor Guest At 99th Annual Meeting

Dr. Charles L. Hudson of Shaker Heights, Ohio, President Elect of the American Medical Association, will be a guest of honor at the 99th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 25-27.

Charles L. Hudson, M. D.

Dr. Carl B. Hall of Charleston, Chairman of the Program Committee, said Doctor Hudson has accepted an invitation to speak at the first session of the House of Delegates on Wednesday afternoon, August 24.

A native of Merrill, Michigan, Doctor Hudson will be installed as President of the AMA next June in Chicago. He was elected to the AMA Board of Trustees in 1961 and was re-elected the following year to a five-year term. He was named President Elect during the AMA meeting in New York City last June.

Doctor Hudson received his M. D. degree in 1930 from the Medical School of the University of Michigan. After his internship and residency at Lakeside Hospital in Cleveland, he accepted a two-year research fellowship in pharmacology at the University of Pennsylvania. He returned to Lakeside Hospital as Chief Resident Physician in medical service, 1934-35.

A Diplomate of the American Board of Internal Medicine, Doctor Hudson has specialized in that field for 30 years. In addition to his practice, he holds associate professorships in medicine and preventive medicine at Western Reserve University. He is also director of the University Health Service.

Doctor Hudson is a member of the Cleveland Academy of Medicine and the Ohio Medical Society, which he served as President in 1955-56. He also is a Past President of the Cuyahoga County Medical Society.

During World War II, Doctor Hudson served as a Lieutenant Colonel in the Medical Corps.

He was married in 1937 to the former Ruth Strong, and they have three children.

Meeting Plans Progressing

The Program Committee has been at work since last September making arrangements for the 99th Annual Meeting. Several prominent physicians and surgeons have accepted invitations to appear as speakers, and their names will be announced in future issues of *The Journal*.

General Scientific sessions will be held on Thursday, Friday and Saturday mornings, August 25-27. Sections and affiliated societies will meet during the afternoon hours.

Serving with Doctor Hall on the Program Committee are Drs. William E. Gilmore of Parkersburg, W. Gene Klingberg of Morgantown, and Halvard Wanger of Shepherdstown.

House To Meet Twice

The House of Delegates will meet twice during the meeting. The first session will be held Wednesday afternoon, August 24. The concluding session will be Saturday afternoon, August 27.

The Pre-Convention Meeting of the Council will be held on Wednesday morning.

Auxiliary Planning Entertainment

As in the past, the entertainment program will be under the supervision of the Woman's Auxiliary. The Program Committee has set aside Friday evening, August 26, for the main entertainment program for physicians, their wives and guests.

W. Va. Chapter, ACS, To Meet At The Greenbrier, Apr. 14-16

The annual meeting of the West Virginia Chapter of the American College of Surgeons will be held at The Greenbrier in White Sulphur Springs, April 14-16.

Dr. Edgar F. Heiskell, Jr., of Morgantown, the President, announced that the following two out-of-state surgeons will appear as speakers during the three-day meeting:

Dr. Leonard F. Peltier, Professor of Surgery, University of Kansas School of Medicine, Kansas City.

Dr. Colin G. Thomas, Jr., Professor of Surgery, University of North Carolina School of Medicine, Chapel Hill.

Drs. Peltier and Thomas will present papers at each of the three general scientific sessions during the morning hours.

In addition to the out-of-state speakers, papers will be presented by members of the Chapter. The two winners of the Chapter's annual contest for residents in West Virginia hospitals also will present their papers during the meeting.

A cordial invitation to attend the meeting has been extended by the West Virginia Chapter to all practicing physicians in the State.

Raleigh Medical Gives $500 To Parents League

The Raleigh County Medical Society has donated $500 for the operation of the Raleigh County Parents League.

Dr. Richard G. Starr, President of the Society, said the sum represented fees paid to member physicians for conducting physical examinations in connection with Project Head Start.

Dr. Warren D. Elliott, League Chairman and a member of the Medical Society, said the donation would be earmarked for clerical work and supplies and would pay the cost of printing questionnaires to be issued to students and parents.

Maryland Medical Announces Meeting Program

The 168th Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland will be held in Baltimore and aboard the S. S. Argentina, April 27 to May 4.

During April 27-28, the sessions will be conducted in Baltimore. The remainder of the meeting will be aboard ship on a cruise to Bermuda.

There is no registration fee, and the meeting has been approved for credit by the American Academy of General Practice.

A program and other information may be obtained by writing to Dr. John Collins Harvey, Chairman, Committee on Program and Arrangements, Medical and Chirurgical Faculty, 1211 Cathedral Street, Baltimore, Maryland 21201.

Doctor Hudson Will Address County Officers Workshop

Dr. Charles L. Hudson of Shaker Heights, Ohio, President Elect of the American Medical Association, will be the principal speaker at a one-day County Medical Society Officers Workshop which will be held at the Daniel Boone Hotel in Charleston on Sunday, March 13. The meeting will be called to order at 9:30 A. M.

Doctor Hudson will deliver the keynote address.

Dr. Seigle W. Parks, the President, announced that officers of the 28 component medical societies have been invited to attend the meeting. He also stressed that attendance definitely is not limited to the officers and that all interested physicians are cordially invited to attend.

Doctor Parks said that one of the purposes of the Workshop will be to discuss the duties and responsibilities of the various committees of the Association and their relationship with similar committees on the local level.

The morning session will be devoted to brief reports by the Chairmen of several of the key committees. There will be ample time for questions and answers and it is hoped that many questions pertaining to the activities of the Association will be fully discussed and answered.

'Current Challenges To Medicine'

Doctor Parks will serve as moderator for a panel discussion on "Current Challenges to Medicine" during the afternoon session. The subjects for discussion will include Implementation of the Medicare Law, Formation of Utilization Review Committees and Medical Education on the undergraduate, graduate and postgraduate levels.

Additional information concerning the program for the Workshop may be obtained by writing the headquarters office, Box 1031, Charleston, W. Va. 25324.

Institute On Utilization Review

Another important conference has been arranged for the Daniel Boone Hotel in Charleston on Saturday, March 12, the day preceding the Officers Workshop.

The State Medical Association and the West Virginia Hospital Association will sponsor an "Institute on Utilization Review." Several of the country's most prominent authorities in this field will be present to discuss this important phase in the implementation of PL 89-97 (Medicare).

Invitations to this meeting have been extended to hospital administrators, chiefs of staff, chairmen of utilization review committees, representatives of the hospital boards of trustees, and directors of Blue Cross-Blue Shield plans.

Physicians planning to attend the Workshop on March 13 also are encouraged to attend the Institute the preceding day.

Ambulance and Aid Study Ends First Phase

The initial phase of a three-year project to improve emergency transportation and immediate care of the sick and injured in West Virginia has been completed by the State Department of Health.

The project was initiated by State Health Director N. H. Dyer because of state and national interest by the U. S. Public Health Service and leading medical authorities regarding the adequacy and quality of emergency transportation and immediate care. These authorities, concerned about the extent of damage that often occurs following an accident, agree that a high proportion of accident victims can expect only poor to fair emergency handling.

The project, financed by a federal Community Health Services grant, is in cooperation with the U. S. Public Health Service, West Virginia University School of Medicine, and the State Funeral Directors Association, among others. It will encompass three annual phases.

The first phase of the project entailed an inventory by visitation to all providers of emergency transportation and immediate care. A survey form was developed through consultation with knowledgeable persons as a guide for procuring comprehensive information. Information obtained included number and type of vehicles, transported equipment, recruitment requirements, level of personnel training in first aid, number of trips, types of emergencies, non-emergent calls, number of emergent and non-emergent child births, misuse of ambulance service, fees, profit and loss, etc.

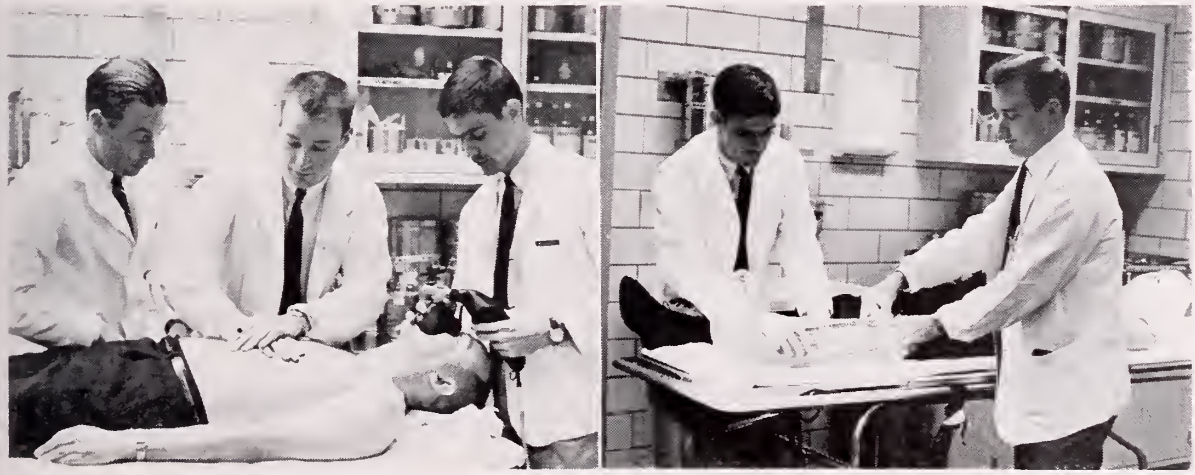
The inventory, statistically enumerated and analyzed by the University Computer Center and Dr. Alfred E. Drake of the University's Division of Statistics, pointed up the following pertinent information: (1) approximately 83 per cent of emergency transportation and immediate care in the state is provided by funeral directors, (2) the level of training acquired by ambulance attendants is generally inadequate, (3) equipment provided for care of injuries is in many instances basic and insufficient, (4) there is no uniform rate of charge, (5) ambulance service provided by funeral directors is in nearly all instances at a financial loss, (6) quite often considerable delay is experienced at the site of definitive care, (7) there was nearly universal agreement that comprehensive training of ambulance attendants is critically needed and was universally endorsed. Other inadequacies in providing comprehensive services were apparent from the analysis.

Two-day regional training sessions throughout the state for ambulance attendants, rescue squads, police and fire department personnel, and other interested persons will encompass the second and primary phase of the project. The sessions are now being initiated and regional sites have tentatively been selected: Charleston, Huntington, Clarksburg, Wheeling, Parkersburg, Weston, Elkins, Bluefield, Logan, and Romney. Supplemental sessions, to be located within the framework of the selected sites, will be provided for persons unable to attend the regional meetings.

Dr. Clark K. Sleeth, Dean of the West Virginia Medical School, has endorsed the project and will assist in procuring traveling instructors from the University's medical complex for the development of the training program and its curriculum. The project welcomes the participation of local interested physicians and members of the Trauma Committee in the training sessions.

The third phase of the project will be introduced in January, 1967, and will primarily consist of further education and an attempt to develop a demonstration project in some state community to be selected on the basis of community interest and need.

"A Study to Improve Emergency Transportation and Immediate Care for the Sick and Injured in West Virginia," has been endorsed by the West Virginia State Medical Association, West Virginia Funeral Directors Association, West Virginia University Medical Center, West Virginia Hospital Association, West Virginia State Safety Council, and the West Virginia Department of Public Safety.



Dr. N. W. B. Craythorne (left), Chairman of the Division of Anesthesiology at the WVU School of Medicine, supervises application of cardiac massage by John H. Ellyson. Also treating "patient" Tom Amend is George P. Hlusko. In right panel, Messrs. Hlusko and Ellyson apply a leg splint.

Winter Meeting of the Council In Charleston on Jan. 16

The Winter meeting of the Council was held at the Daniel Boone Hotel in Charleston on Sunday, January 16, 1966, with the Chairman, Dr. Albert C. Esposito of Huntington, presiding.

Principal items on the agenda included reports of officers and chairmen of the Medical Economics, Mental Health and Legislative committees. There also were reports on the implementation of the Medicare law in West Virginia and the "Heart Disease, Cancer and Stroke Amendments for 1965."

County Society Officers Workshop

Dr. Seigle W. Parks, the President, announced that a County Society Officers Workshop had been arranged for the Daniel Boone Hotel in Charleston on Sunday, March 13. He said that officers of the 28 component societies would be invited to attend the one-day meeting and he emphasized that the workshop would be open to all interested physicians.

Doctor Parks also said the State Medical Association and the West Virginia Hospital Association would sponsor an "Institute on Utilization Review" at the Daniel Boone Hotel on Saturday, March 12, the day preceding the Workshop. He said that invitations would be extended to hospital administrators, chiefs of medical staffs, chairmen of Utilization Review Committees, representatives of hospital boards of trustees, and directors of Blue Cross-Blue Shield Plans. Physicians attending the Workshop on March 13 also will be invited to attend the Institute.

Report of Legislative Committee

Dr. Frank J. Holroyd of Princeton, Chairman of the Legislative Committee, reported that there had been few bills introduced during the first week of the Legislature which were of interest to the medical profession. He said the Association did not plan to sponsor any bills during the 30-day budget session.

Doctor Holroyd encouraged members of the Council to request their Senators and Delegates to support the budget request submitted by the Commission on Postmortem Examinations.

He pointed out that the Commission had requested an appropriation of $65,000 for the implementation and operation of the Medical Examiners' System during the 1966-67 fiscal year; however, this figure was reduced to $56,800 by the Board of Public Works in its recommendation to the Legislature.

Report of the Medical Economics Committee

Dr. George R. Callender, Jr., Chairman of the Medical Economics Committee, presented a detailed report covering the activities of the various sub-committees during the past few months.

He said that the 1966 contract with the Office for Dependents' Medical Care had not been signed and that the ODMC had been requested to grant an extension on the contract currently in effect, which request was granted in December. The contract was extended until June 30, 1966.

Doctor Callender said this action was necessary in order to conform with the policy adopted by the House of Delegates in August in regards to third-party medical programs. He said that members of the Committee plan to meet with ODMC officials in the near future.

Doctor Callender said that other state and federal agencies had been notified of the change in policy. He said a meeting had been arranged with the Compensation Commissioner and that similar meetings would be held with official representatives of other agencies.

Doctor Callender reported that the Blue Cross-Blue Shield Sub-Committee met recently with the executive directors and presidents of BC-BS plans throughout the State to discuss implementation of the Medicare law.

He stated that the plans voted to designate the Blue Shield Plan in Charleston as the control unit in the administration of Part B, Title XVIII, of the Medicare law. He said that the Charleston Blue Shield Plan had submitted its application to the Department of HEW prior to the December 15 deadline.

Report of Mental Health Committee

Dr. William B. Rossman of Charleston, Chairman of the Mental Health Committee, prepared a report for the Council in which he stated that a meeting of the Committee had been held in Charleston on Saturday evening, January 8.

The primary purpose of the meeting was to discuss the various legislative proposals which would be sponsored by the Department of Mental Health during the 1966 session.

It was reported that the Committee officially endorsed the legislative program of the Department.

Implementation of Medicare Law

Dr. N. H. Dyer, State Director of Health, presented a report on the implementation of Title XVIII of PL 89-97 (Medicare) in West Virginia. Doctor Dyer reported that the Health Department will be directly responsible for the certification, consultation and coordination provisions of Part A of Title XVIII.

He said that a separate unit had been established in the Department to implement the new Medicare law and that he hoped that assistance would be forthcoming from the officers and individual members of the State Medical Association.

Report by Dr. Clark K. Sleeth

Dr. Clark K. Sleeth, Dean of the West Virginia University School of Medicine, presented a report on a meeting which had been held in Morgantown in December for the purpose of discussing the "Heart Disease, Cancer and Stroke Amendments of 1965," as adopted by Congress.

Doctor Sleeth reported that an advisory committee would be named and that several physicians would be included among the members. He asked the Council to submit the names of several physicians as its nominees for membership on the Committee.

The Council voted to authorize the President of the State Medical Association to designate three physicians to serve as members of the advisory committee.

Mr. James H. Boso Guest At Meeting

Mr. James H. Boso, President of the Student American Medical Association Chapter at the West Virginia University School of Medicine, was a guest at the meeting. He said he appreciated the opportunity to attend the meeting and extended best wishes from the students enrolled in the West Virginia University School of Medicine.

The following members of the Council were present at the meeting: Dr. Albert C. Esposito of Huntington, Chairman; Dr. Seigle W. Parks of Charleston, President; Dr. Richard E. Flood of Weirton, President Elect; Dr. Richard V. Lynch, Jr., of Clarksburg, Vice President; Dr. Kenneth G. MacDonald of Charleston, Treasurer; and Drs. Joseph L. Curry of Wheeling; Maynard P. Pride of Morgantown; Andrew J. Weaver of Clarksburg; R. L. Chamberlain of Buckhannon; I. Ewen Taylor of Huntington; and Mr. William H. Lively, Secretary ex officio, and Mr. Edward D. Hagan, Executive Assistant.

The meeting also was attended by Dr. Frank J. Holroyd of Princeton, AMA Delegate; Dr. C. A. Hoffman of Huntington, AMA Delegate; Dr. Thomas G. Reed of Charleston, AMA Alternate; Dr. N. H. Dyer, Charleston, Director, State Department of Health, Dr. George R. Callender, Jr., of Charleston, Chairman of the Medical Economics Committee; Dr. Clark K. Sleeth, Dean, WVU School of Medicine; Mr. David B. Weihaupt of Chicago, AMA Field Representative, and Mr. James H. Boso of Morgantown, President of the SAMA Chapter at the WVU School of Medicine.

AAP Meeting At Montreal April 25-27

More than 3,000 pediatricians, their families and guests are expected to attend the spring meeting of the American Academy of Pediatrics at the Queen Elizabeth Hotel in Montreal, April 25-27.

The scientific program will feature closed circuit television presentations on cerebral palsy, learning disorders and growth problems. Scientific presentations will cover subjects including newborn and prematurity, problems of carbohydrate metabolism, management of cardiac failure in children with acyanotic congenital heart disease, pulmonary hypertension, pediatric surgery and genetics and congenital disorders.

The meeting is open to non-pediatricians. Registration fees are $15 for members of the Academy, applicants to the Academy, applicants to the American Board of Pediatrics, nonmembers out of school less than five years, and physicians in the Armed Forces. Registration fee for nonmember physicians is $25.

Persons interested in attending the meeting should write for a preliminary program and housing and registration forms to the American Academy of Pediatrics, 1801 Hinman Avenue, Evanston, Illinois 60204.

47th Annual Meeting of ACP In New York City

The 47th annual meeting of the American College of Physicians will be held in New York City, April 18-22.

Five days of scientific sessions at the Americana and New York Hilton hotels are planned for the internists with presentations by more than 300 medical scientists. Highlights will include lectures by experts in the fields of liver disease, cardiology, cellular replacement, cholera and dietary protein deficiency.

Irving S. Wright, M. D.

Dr. John P. Merrill, Boston surgeon, will report on the present status of kidney transplantation.

The program will include plenary sessions, panel discussions, special lectures, closed circuit television programs, basic science and clinical investigation presentations. Other features will be the annual business meeting of the ACP and a convocation at which about 600 physicians will become Fellows of the College.

The schedule will begin on Monday morning, April 18, with an address by Dr. A. Carlton Ernstene of Cleveland, President of the ACP. He will be succeeded as President by Dr. Irving S. Wright of New York City.

A reception and dinner dance, the only social event on the five-day program, will be held Thursday, night.

Programs and other information about the meeting may be obtained by writing to Dr. Edward C. Rosenow, Jr., Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

Symposium on Ear Surgery

A one-day program on current trends in middle ear surgery will be held in Newark, New Jersey, May 18.

The symposium is being sponsored by the Academy of Medicine of New Jersey and the New Jersey Academy of Ophthalmology and Otolaryngology. Registration fee will be $10.

Requests for additional information should be addressed to: Academy of Medicine of New Jersey, 317 Belleville Avenue, Bloomfield, New Jersey, before May 1.

Seminar In Cincinnati

The Good Samaritan Hospital of Cincinnati will conduct its Fourth Annual Seminar on Premature Care on Thursday afternoon, April 21.

There is no registration fee, but persons planning to attend should contact Dr. Ernst G. Rolfes, Chairman, Seminar on Premature Care, Good Samaritan Hospital, Cincinnati.

Cigarettes Are Becoming Popular Again

In a recent issue of the "State of the State's Health," State Health Director N. H. Dyer noted that the yearly rate of cigarette consumption, based on the number per person 18 and older, is climbing back—almost to the record high of 1963.

Doctor Dyer said that studies show that approximately 70 million people in the United States habitually smoke cigarettes, that hundreds of thousands of teenagers join their ranks annually with one half of all graduating high school seniors already caught in the habit, and that about one million of the students in our junior and senior high schools today will die of cigarette-induced lung cancer before they are 70.

"These are realities that should be both personal and professional challenges to everyone," Doctor Dyer stated. "The threat is clear and public health practitioners now have the responsibility of meeting this threat with all available resources." Doctor Dyer added that some of the educational aids available from the State Health Department to persons engaged in smoking and health programs included speakers, medical papers, kits, films, posters, and pamphlets.

Doctor Dyer devoted another recent issue of the "State of the State's Health," to smoking in which he directed attention to a new pamphlet prepared by the Philadelphia Smoking and Health Research Project. The pamphlet, "Cigarette Smokers: You Are Gambling With Your Life!" lists eight cigarette smokers' odds:

—The regular cigarette smoker runs a risk of death from lung cancer 10 times greater than that for the non-smoker.

—The death rate from coronary heart disease is 70 per cent greater for cigarette smokers than non-smokers.

—If you smoke two packs of cigarettes a day, your overall death rate is twice that of non-smokers.

—If you smoke two packs of cigarettes a day and quit, you will save over $16 a month.

—The regular cigarette smoker is six times more likely to develop fatal respiratory diseases than non-smokers.

—Your children will probably smoke if you set the example by smoking.

—Studies show that 90 per cent of lung cancer patients are cigarette smokers.

—Regular cigarette smokers who quit for a year or more have a 50 per cent lower death rate than those who continue to smoke.

"The goal and ultimate responsibility of public health practitioners is to make certain that if an individual decides to take up or to continue smoking, he does so with full awareness of the possible consequences to his health," Doctor Dyer concluded.

Dr. Bradford Elected Trustee

Dr. Bert Bradford, Jr., of Charleston, has been elected to the Board of Trustees at Morris Harvey College.

New Form for Social Security Disability Determination

The Social Security Administration has devised a new type of medical history form for use in determining disability claims.

The major difference is that the new form takes the shape of a narrative rather than a questionnaire type.

After its submission, if the report lacks sufficient information on which to base a determination, the physician reviewing the claim may telephone the examining physician for additional information.

The new procedure was announced by Dr. William S. Herold of The State Division of Vocational Rehabilitation, the state agency that makes determinations for the Social Security program.

"Generally, the treating physician can provide all the medical evidence we need for determining whether the patient is disabled," Doctor Herold said. "Now we hope to benefit more than ever from the physician's resources while best suiting his convenience."

According to Doctor Herold, physicians' preferences led to replacing the old-style questionnaire. Studies in six states demonstrated that doctors could give a clearer, more complete clinical picture of a claimant by using a narrative format.

Heart Fund Grant Requests Due By April 1

The West Virginia Heart Association has set April 1 as the deadline for receiving applications for research grants-in-aid from investigators in West Virginia working in the cardiovascular field.

Grants are not restricted to any particular discipline, but the investigator must be qualified and have facilities available to pursue his work. Although no maximum grant has been established, individual requests should not exceed $3,000.

Grants are awarded by the West Virginia Heart Association to scientists who need interim or supplementary support for on-going projects or who wish to demonstrate by pilot experiments the value of a new project. The program is separate from that of the American Heart Association.

Applications and additional information may be obtained by writing to: Mr. O. D. Wyatt, Executive Director, West Virginia Heart Association, 759 West Washington Street, Charleston, West Virginia 25302.

Dr. E. W. Squire Named Fellow

Dr. Everett W. Squire of Charleston was among 55 radiologists granted the degree of Fellow of the American College of Radiology during the annual meeting of the College in Chicago, February 1-5.

The College grants the degree of Fellow to certified radiologists who have given distinguished service to their specialty. Less than 1,000 of approximately 5,600 members of the College hold the degree of Fellow.

W. Va. Acad. of Oph. and Otol. To Meet At The Greenbrier, April 13-16

The West Virginia Academy of Ophthalmology and Otolaryngology will conduct its 19th annual meeting at The Greenbrier in White Sulphur Springs, April 13-16. Dr. Ralph W. Ryan of Morgantown, the President, will preside during the four-day meeting.

Doctor Ryan announced that six physicians, five of them from out-of-state, have accepted invitations to present papers at the scientific sessions.

Philip Sprinkle, M. D.

H. Saul Sugar, M. D.

An intensive one-day contact lens course will be held on April 13 from 9 A. M. to 5 P. M. Mr. Philip Salvatori of Obrig will present advanced fitting and scleral molding techniques.

The speakers on ophthalmology and their subjects are as follows:

"Contact Lenses in Corneal Pathology, after Keratoplasty and in Children," and "Corneal Edema." Jorge Buxton, M. D., New York City.

"Recent Advances in Medical and Surgical Treatment," and "Iatrogenic Complications in Ophthalmology."—William F. Hughes, M. D., Chicago.

"Troublesome Problems in the Management of Adult Primary Glaucoma," and "Surgical Treatment of Adult Primary Glaucoma."—H. Saul Sugar, M. D., Detroit.

Speakers on otolaryngology and their subjects are as follows:

"Considerations Concerning the Congenital Middle Ear," and "Surgical Management of Obliterative Otosclerosis."—T. Manford McGee, M. D., Detroit.

"Laryngeal Injuries, the Management of Recent Injuries and Their Sequelae (Chronic Stenosis)," and "Evaluation and Treatment of Advanced Stages (Stages 3 and 4) of Cancer of the Larynx." —Charles M. Norris, M. D., Philadelphia.

"Salivary Glands."—Philip Sprinkle, M. D., Morgantown.

Physicians throughout the state have been invited to attend the four-day meeting. A registration fee of $35 for nonmembers covers the scientific sessions and the social functions.

In addition to Doctor Ryan, the other officers of the Academy are as follows: Dr. Worthy W. McKinney of Beckley, President Elect; Dr. J. Elliott Blaydes, Jr., of Bluefield, Secretary-Treasurer. The directors are Drs. William C. Morgan, Jr., and Alfred J. Magee of Charleston, and Edward Shupala of Parkersburg.

Additional information may be obtained by writing to the Secretary, Dr. J. Elliott Blaydes, Jr., 107 Federal Street, Bluefield.

Blue Shield Will Sponsor 1966 Welch Award

The National Association of Blue Shield Plans will sponsor the 1966 Norman A. Welch, M. D., Memorial Award Program.

The award will be made to the author of the most scholarly and meritorious contribution to the literature of medical economics between last July 1 and next June 30. The contribution may be an article or series of articles, a book, or a published or delivered speech.

Initiated in 1965, the award consists of a gold medallion and a $1,000 contribution in the author's name to the Norman A. Welch, M. D., Memorial Fund of the American Medical Association's Education and Research Foundation.

The National Association of Blue Shield Plans established the award to honor Doctor Welch, who died in September 1964 while serving as President of the American Medical Association.

A three-man committee composed of representatives of the American Medical Association, the American Medical Writers' Association and the Board of Directors of the National Association of Blue Shield Plans will select the winner of the award.

Authors may submit entries to: Library, National Association of Blue Shield Plans, 425 North Michigan Avenue, Chicago, Illinois 60611. Deadline is September 1.

PG Course In Internal Medicine

The American College of Physicians will offer a postgraduate course in "Basic Mechanisms in Internal Medicine" in Toronto, Ontario, March 28-April 1.

The course is to be oriented toward the clinician who is interested in scientific mechanisms and the rationale of treatment. It will be given by a faculty selected from both basic science and clinical departments of the University of Toronto, emphasizing areas in which active research is being carried out.

Fees are $60 for ACP members and $100 for nonmembers.

Registration forms and other information may be obtained by writing to Dr. Edward C. Rosenow, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

Dr. Hu C. Myers Installed As Kiwanis Governor

Dr. Hu C. Myers of Philippi has assumed duties as West Virginia District Governor of Kiwanis International.

The installation of Doctor Myers and other officers took place at a dinner in Philippi on January 8.

Congress on Environmental Health Problems

The Third AMA Congress on Environmental Health Problems will be held in Chicago, April 4-5.

Discussions will focus on the impact of environment on accidental injuries and fatalities. The program is acceptable for 12 accredited hours by the American Academy of General Practice.

A registration fee of $10, payable at the time of registration in Chicago only includes admission, two luncheons, reception and a copy of the proceedings.

Registration blanks and other information may be obtained by writing to the Department of Environmental Health, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Acting Superintendent Named At Colin Anderson Center

State Mental Health Director Mildred Bateman has announced the appointment of Dr. Ernest Andia as Acting Medical Superintendent at the Colin Anderson Center at St. Marys.

A native of Spain but now a citizen of the United States, Doctor Andia has been senior psychiatrist at Gardner State Hospital in Massachusetts for the last five years.

The Colin Anderson Center is a facility for retarded children.

MCV Names Doctor Caravati As Assistant Dean

Dr. Charles M. Caravati has been appointed Assistant Dean and Director of Continuation Education of the School of Medicine of the Medical College of Virginia in Richmond.

A practicing physician in Richmond for 43 years, Doctor Caravati received his M. D. degree from MCV in 1922 and completed his postgraduate training at Johns Hopkins.

As a Professor of Medicine, Doctor Caravati will continue as Chief of the Sub-section of Gastroenterology.

Einstein Medical Center Symposium

More than 500 physicians are expected to attend a three-day symposium on vascular disease to be sponsored by the Albert Einstein Medical Center in Philadelphia, March 28-30.

Thirty-eight scientific papers will be presented. Topics will include diagnostic procedures; obstructive and inflammatory diseases of venous and lymphatic systems; aneurysm; arterial embolism; coagulation and biophysical aspects of vascular disease; renovascular hypertension; and extracranial cerebrovascular disease.

Registration fee is $30 and physicians interested in attending must register in advance. Additional information may be obtained by writing to Dr. Aaron D. Bannett, Symposium Office, Albert Einstein Medical Center, York and Tabor Roads, Philadelphia, Pennsylvania 19141.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled for the next year.

1966

March 4-9—Am. Assn. of Pathologists & Bacteriologists, Cleveland.
March 5-6—AMA Cong. on Med. Ethics & Professionalism, Chicago.
March 5-10—Int. Acad. of Path., Cleveland.
March 14-17—ACS Sectional Meeting, Cleveland.
March 18-19—AMA Rural Health Conf., Colorado Springs.
April 13-16—W. Va. Academy Oph. and Otol., White Sulphur Springs.
April 13-16—Am. Radium Soc., Phoenix.
April 14-16—W. Va. Chapter, ACS, The Greenbrier, White Sulphur Springs.
April 15-17—Am. Soc. of Int. Medicine, New York.
April 18-22—ACP, New York.
April 21-23—W. Va. Soc. of Medical Technologists, Martinsburg.
April 25-28—Industrial Med. Assn., Detroit.
April 25-30—Am. Acad. of Neurology, Philadelphia.
April 25-29—Am. Col. of Allergists, Chicago.
April 27-29—Am. Ped. Soc., Inc., Atlantic City.
April 27-May 4—Maryland Med. Soc., Baltimore.
April 28-30—Va. Soc. of Oph. & Otol., Charlottesville.
April 29-May 1—W. Va. Chapter, AAGP, Charleston.
May 1-4—American Col. Ob.-Gyn., Chicago.
May 1—Am. Fed. for Clinical Research, Atlantic City.
May 2-5—Am. Col. of Ob.-Gyn., Chicago.
May 9-13—American Psychiatric Assn., Atlantic City.
May 11—Am. Cancer Soc., San Francisco.
May 18-22—Pa. Acad. of Oph. & Otol., Bedford Springs.
May 22-27—Ohio State Medical Assn., Cleveland.
May 22-25—National TB Assn., San Francisco.
May 23-25—Am. Thoracic Soc., San Francisco.
May 30-June 1—Am. Ophthalmological Soc., White Sulphur Springs.
May 30-June 2—American Urol. Assn., Chicago.
June 2-4—American Gyn. Soc., Hot Springs, Va.
June 17-18—Am. Rheumatism Assn., Denver.
June 23-27—ACCP, Chicago.
June 24-25—Am. Geriatrics Soc., Chicago.
June 25-26—Am. Diabetes Assn., Chicago.
June 26-30—AMA Annual Meeting, Chicago.
July 7-9—Am. Med. Women's Assn., Rochester, N. Y.
July 10-14—Med. Women's Int. Cong., Rochester, N. Y.
Aug. 25-27—W. Va. State Medical Assn., White Sulphur Springs.
Aug. 29-Sept. 1—Am. Hosp. Assn., Chicago.
Sept. 8-10—Am. Assn. of Ob.-Gyn., Hot Springs, Va.
Sept. 9—Maryland Medical, Ocean City.
Sept. 16-24—Am. Soc. of Clinical Path., Washington.
Sept. 20-22—Kentucky Medical, Louisville.
Sept. 23-24—W. Va. Heart Assn., Morgantown.
Sept. 23-27—Col. of Am. Pathologists, Chicago.
Sept. 23-Oct. 1—Am. Soc. of Clinical Pathologists, Chicago.
Oct. 1-5—Am. Soc. of Anesthesiologists, Philadelphia.
Oct. 10-13—AAGP, Boston.
Oct. 10-14—ACS, San Francisco.
Oct. 16-21—Am. Acad. of Oph. & Otol., White Sulphur Springs.
Oct. 21-23—Am. Heart Assn., New York.
Oct. 22-27—Am. Acad. of Pediatrics, Chicago.
Nov. 6-9—Med. Soc. of Virginia, Williamsburg.
Nov. 14-17—Southern Med. Assn., Washington.
Nov. 26-27—Am. Col. of Chest Physicians, Las Vegas.
Nov. 27-30—AMA Clinical Convention, Las Vegas.

The West Virginia Medical Journal

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The Treatment of Diabetic Acidosis

E. K. Apostolou, M. D., and Edmund B. Flink, M. D.

Introduction

The successful management of diabetic acidosis requires a thorough understanding of the precipitating factors and the pathological physiology of the desease itself. Rapid evolution of events leads to the life-threatening medical emergency of diabetic acidosis. The absolute requirement for insulin has been appreciated since the discovery of insulin. There has been a gradual increase in the average dose used. The importance of fluid and electrolyte losses during the development of acidosis and the need for their replacement for a complete recovery are now clearly recognized.

This report presents clinical material accumulated at the West Virginia University Hospital, pertaining to the treatment of diabetic acidosis, discusses the rationale of electrolyte and fluid replacement and suggests a practical form of treatment.

Clinical Material

During the years 1961 through 1964, 18 episodes of diabetic acidosis were treated in the West Virginia University Hospital. Two of the patients were admitted twice and a third patient five times because of acidosis. All patients had hyperglycemia, a carbon dioxide (CO_2) content of less than 15 mEq/l., Kussmaul breathing, and a positive plasma acetone test.

In each case, the state of consciousness, the laboratory findings associated with the acidosis, the urine output, the amount of insulin, and the fluids and electrolytes given during the first 24 hours of treatment are tabulated.

The rationale and general pattern of fluid and electrolyte replacement employed in the treatment of these cases are indicated in the discussion. One patient, who was severely ill when he entered the hospital, with a blood sugar of 2000 mg. per 100 ml. and a CO_2 of 9 mEq/l., died within one hour after the start of treatment, before substantial amounts of fluid could be given. This was the only death. Patients 5, 10, 11 and 14 were mildly or moderately acidotic.

Four representative cases are reported in detail.

Case 1.—This 63-year-old known diabetic, white female was comatose when admitted to the West Virginia University Hospital. Diabetes had been discovered six years previously, following an episode of coma. She had been maintained on 50 units of NPH insulin daily for the preceding six years. Two weeks prior to admission dysuria developed. She was treated with Oxytetracycline. Beginning two days before admission, she experienced repeated bouts of vomiting. On the afternoon of the day of admission, she became lethargic, and a sweet, fruity odor was noted on her breath. She became stuporous and disoriented and was taken to another hospital. Tests for sugar and acetone in the urine were strongly positive. The blood sugar was 1100 mg. per 100 ml. and the CO_2 1.8 mEq/l. at that time. She was given 150 units of NPH insulin and 1,000 ml. of M/6 sodium lactate, and then was referred to this hospital.

The Authors

- E. K. Apostolou, M. D., and Edmund B. Flink, M. D., Department of Medicine, West Virginia University School of Medicine, Morgantown.

Submitted to the Publication Committee, July 28, 1965.

On physical examination, she was comatose. Her blood pressure was 130/80. She had Kussmaul breathing and the skin was dry, with poor turgor. There was an acetone odor on her breath. Basilar rales were audible. The deep tendon reflexes were present bilaterally, and there were no abnormal reflexes. The hemoglobin on admission was 14.6 Gm. per 100 ml., the leukocytes were 18,400, with a shift to the left of neutrophils. The blood sugar was 1320 mg. per 100 ml.; the CO_2 4 mEq/l; the sodium (Na), 137 mEq/l; the potassium (K), 2.5 mEq/l; and the blood urea nitrogen (BUN), 55 mg. per 100 ml. Table 1 records the amounts of regular insulin, fluids, and electrolytes given during the first 24 hours. She had a total amount of 880 units of regular insulin and 8,600 ml. fluids. Nine hours after admission, her blood sugar was 334 mg. per 100 ml.; the CO_2, 26 mEq/l.; the K, 2.8 mEq/l; the Na, 141 mEq/l.; and the BUN, 41 mg. per 100 ml. Recovery was uneventful.

Case 2.—This 58-year-old white female was admitted to the West Virginia University Hospital in a comatose state which had begun on the morning of admission. She had been well until one year before admission, but since that time she had lost 40 pounds. One month before admission she did not feel well and began having episodes of nocturia and abdominal pain. A few days before admission she noted extreme thirst, polydipsia, polyuria and nocturia. She also gave a history of having borne one very heavy baby.

On physical examination, she was deeply comatose. The blood pressure was not obtainable initially, but after some intravenous fluid, it was 70/30, then rose and remained at a level of about 100 systolic for many hours. She was dehydrated, had an acetone odor on her breath and had Kussmaul type breathing. The mucous membranes were dry. The eyes were soft.

Laboratory.—On admission, hemoglobin was 15.4 Gm. per cent, the leukocyte count was 22,000, with a shift to the left, and neutrophils 87 per cent, lymphocytes 11 per cent, monocytes 2 per cent. A blood sugar was 1080 mg. per 100 ml., the CO_2, 2 mEq/l.; the Cl, 110 mEq/l.; the Na, 147 mEq/l.; the K, 5.5 mEq/l.; the pH 7.0; the BUN, 65 mg. per 100 ml. Table 2 records the amounts of regular insulin, fluids, and electrolytes that she received during the 24 hours following admission. She received a total of 735 units of regular insulin and 9 liters of fluid. Seventeen hours after admission, her blood sugar was 200 mg. per 100 ml., the CO_2, 15 mEq/l.; the Na, 140 mEq/l.; the K, 4.1 mEq/l.; the BUN, 28 mg. per 100 ml. She began to arouse from her comatose state in about 24 hours and then rapidly improved. At the time of discharge she was re-

TABLE 1

HOURS AFTER INITIATION OF TREATMENT

	0	2	4	5	7	10	11	15	17-24	Total	Amount per kg. of Body Wt.
Reg. Insulin Units	180	80	80	160	160	70	20			880	
Water ml.	1500	1000	1000	1000	1000	100	1000	1000	1000	8600	148
Sodium mEq	239	144	94		50				40	578	10
Chloride mEq	140	100	50	40	50	6	60	40	110	596	10
Potassium mEq	40			80	40	6	60	40	60	326	5.6
Bicarbonate mEq	89	44	44							178	
Magnesium mEq				16	16	1.7	16		16	66	1.2
Phosphate mEq				40	40					80	1.3
Glucose Gm.						5	50	50		105	
Lactate mEq	80										
State of Consciousness:	Stuporous		Alert								

TABLE 2

HOURS AFTER INITIATION OF TREATMENT

	0	2	4	5	7	10	16	21	24-26	Total	Per kg. of Body Wt.
Reg. Insulin Units	100	50	100	50	75	175	75	20		645	
Water ml.	1000	1000	1000	1000	1000	1000	1000	1000	1000	9000	160
Sodium mEq	138	144	94	50	50		50	50		576	10
Chloride mEq	50	100	50	90	50		50	50		440	8
Potassium mEq				40	40	40	40	40	40	240	4
Bicarbonate mEq	88	44	44							178	
Magnesium mEq					16	16	16	16	16	80	1.5
Phosphate mEq					40	40	40	40	40	200	3.5
Glucose Gm.					50	50	50	50	50	250	
State of Consciousness:	Comatose							Stuporous, drowsy			

ceiving a dose of 35 units of NPH insulin and an 1800 calorie diet.

Case 3.—This 27-year-old white female known diabetic for seven years was admitted to the West Virginia University Hospital because of abdominal pain, nausea and vomiting. She was taking 35 units of NPH insulin daily and had achieved good control until the morning of the day of admission, when she awoke with periumbilical pain, nausea, vomiting, and diarrhea. Because of anorexia she did not eat well all day and she omitted her insulin. She came to the hospital at 7:00 P. M.

On physical examination, she was alert. The blood pressure was 150/80, the pulse rate 110 per minute and the respirations were of the Kussmaul type. An odor of acetone was detected on her breath, and she appeared to be dehydrated. There was considerable diffuse abdominal distention and tenderness, with muscle guarding in both lower quadrants and diffuse rebound tenderness. The bowel sounds were hyperactive. On the plain abdominal films there appeared to be distention of the stomach with a large amount of fluid. The small bowel did not appear to be unusually distended. There was no subdiaphragmatic gas. The laboratory findings were blood sugar 486 mg. per 100 ml.; the CO_2, 8 mEq/l.; the Na, 127 mEq/l.; the Cl, 104 mEq/l.; the K, 5.9 mEq/l.; BUN, 30 mg. per 100 ml.; the hemoglobin, 15 gm. per 100 ml.; the hematocrit, 47 per cent; leucocyte count 31,500, neutrophils 89, lymphocytes 11 per cent and monocytes 1 per cent. The clinical and laboratory findings were strongly suggestive of an acute inflammatory abdominal process, possibly appendicitis, precipitating the diabetic acidosis. The necessity for emergency surgical intervention was discussed, but it was decided to treat the diabetic acidosis vigorously and to observe closely the abdominal condition. It would be necessary, of course, to treat the acidosis effectively before undertaking surgery. Nasogastric suction was instituted immediately. Soon after onset of treatment of the acidosis, the patient felt better and the abdominal tenderness and distention decreased. By the end of the first 24 hours, she had no abnormal abdominal findings. The leucocyte count 12 hours after admission was 19,500, and 24 hours after admission it was 6,500 per cu. mm. The hemoglobin was 12.2 Gm. and the hematocrit 37 per cent. Table 3 records the amounts of insulin, intravenous fluids, and electrolytes she received during the first 24 hours.

Case 4.—This 42-year-old white female was admitted for the first time to the West Virginia

TABLE 3

HOURS AFTER INITIATION OF TREATMENT

	0	3	5	7	9	11	17-24	Total	Per kg. of Body Wt.
Reg. Insulin Units	80	80	50	50	50		50	360	
Water ml.	1000	1000	1000	1000	1000	1000	1000	7000	134
Sodium mEq	139	144	50	50	50	50		484	9.0
Chloride mEq	50	100	90	50	50	50	40	430	8.0
Potassium mEq			40	40	40	40	40	200	3.8
Bicarbonate mEq	89	44						134	
Magnesium mEq				16	16	16		48	1.0
Phosphate mEq				40	40	40		120	2.3
Glucose Gm.			50	50	50	50	50	250	
State of Consciousness:	Drowsy		Alert						

TABLE 4

HOURS AFTER INITIATION OF TREATMENT

	0	2	3	5	9	15-24	Total	Amounts per kg. of Body Wt.
Reg. Insulin Units	80		40	15		30	165	
Water ml.	1600	1000	1000	1000	1000	1000	6600	101
Sodium mEq	138	94	50	50			332	5.1
Chloride mEq	50	50	90	50	20		260	4.0
Potassium mEq			40	40	60		140	2.1
Bicarbonate mEq	89	44					133	
Magnesium mEq				16	16		32	0.5
Phosphate mEq				40	40		80	1.2
Glucose Gm			50	50	50	50	200	
State of Consciousness:	Stuporous			Alert				

University Hospital in June, 1961, for treatment of a pelvic cyst. Diabetes was discovered in 1953 at the time of an episode of coma. She had had a total hysterectomy in 1959. She had been maintained on 30 to 40 units of NPH insulin daily, but her insulin intake was irregular and often entirely omitted due to her alcoholism. She was readmitted in August, 1961, because of recurrence of left lower quadrant abdominal pain and signs of mild diabetic acidosis. After adequate diabetic control, a benign ovarian cyst on the left was found at laparotomy and bilateral salpingo-oophorectomy was performed. Subsequently, she was readmitted several times with diabetic acidosis preceded by an alcoholic debauche and failure to eat and take insulin. On one occasion, diabetic acidosis occurred following an acute episode of bronchitis.

On November 5, 1964, she was readmitted following a drinking period and failure to take insulin and food. She also had a cough, right-sided chest pain, and nausea and vomiting. She had a strong acetone odor on her breath, had Kussmaul breathing and was lethargic. Numerous rhonchi were heard in the chest bilaterally. The skin was dry, and its turgor poor. The liver was palpable. Knee and ankle jerks were absent. Sputum culture revealed Diplococcus pneumoniae, but chest x-rays were normal. The blood sugar was 780 mg. per 100 ml.; the CO_2, 9mm/1; the Na, 121 mEq/l.; the K, 5.3 mEq/l.; the BUN, 58 mg. per 100 ml. Table No. 4 records the amount of regular insulin, fluids and electrolytes she received during the first 24 hours. Twenty-one hours after admission, the blood sugar was 194 mg. per 100 ml.; the CO_2, 17 mm/l.; the Na, 130 m Eq/l.; the K, 3.7 mEq/l.; and BUN, 18 mg. per 100 ml.

The total amounts of regular insulin, fluids, and electrolytes given during the first 24 hours and the amounts of intravenous fluids and electrolytes given per kilogram of body weight during this same time interval are tabulated in Tables 5 and 6, respectively.

Discussion

Hyperglycemia results from decreased peripheral utilization and increased hepatic production of glucose. Hyperglycemia is the central problem of diabetic acidosis and, when the level becomes high enough so the kidney tubule's ability to reabsorb glucose is exceeded, massive glucosuria occurs. The maximal urinary concentrating ability drops to half of the normal during solute diuresis. Marked hyperglycemia causes increased extracellular osmolarity and, therefore, intracellular dehydration. There are no serious consequences from the loss of 5 to 20 Gm. of glucose per day, but when the loss is high, i.e., 100 to 200 Gm. per day, catabolism of protein and fat results in excessive hepatic gluconeogenesis from fatty acids and proteins.[1, 2, 3]

If utilization of acetyl coenzyme A through the tricarboxylic acid cycle is impeded by lack of pyruvate, any excess, instead of undergoing oxidation, would be expected to be shunted in the liver for the synthesis of ketone bodies.[1] There is an increased lipolysis and fat oxidation.

TABLE 5

Number	Name	Body wt. in kg.	State of Consciousness*	Reg. Ins. units	Fluids I. V. ml.	Na mEq.	Cl mEq.	HCO_3 mEq.	K mEq.	Mg. mEq.	PO_4 mEq.	Glucose gm.
1	JM	58	4	880	8600	578	596	178	326	66	80	105
2	MF	56	5	645	9000	576	440	178	240	80		250
3	ML	52	2	360	7000	483	430	134	200	48	120	250
4	LM	65	4	165	6600	332	260	134	140	32	80	200
5	DK	50	5	250	7800	483	425	178	120			325
6	DP	57	4	380	8000	627	574	134	160	32	80	300
7	EP	53	2	105	2000	308	308				80	
8	WS	93	3	425	6000	439	430	89	160	32	200	150
9	DV	58	2	160	6000	495	390	264	160		120	250
10	DV	58	4	195	6500	545	491	136	242	48		104
11	CF	56	4	160	4000	423	280	223	80			150
12	CF	52	1	70	3500	384	320	134	70			
13	EC		5	600	750	145	112	33				
14	HK	60	2	215	4000	390	372	45	90	12	25	200
15	LM	65	1	95	1500	179	155	25				100
16	LM	65	2	438	7000	549	585	45	120	32	40	
17	LM	65	5	180	5000	337	244	134	80		40	150
18	LM	65	1	167	3500	332	300	42				

Table No. 5 records the total amounts of Regular Insulin, Intravenous Fluids and Electrolytes received by each patient during the first 24 hours of treatment.

* The numbers represent various states of consciousness:
Comatose 5, Stuporous 4, Lethargic 3, Drowsy 2 and Alert 1.

Glucose exerts a controlling influence on fat metabolism by supplying reduced triphosphopyridine nucleotide through the pentose-phosphate shunt. Deficient TPNH results in decreased lipogenesis.[1, 2]

In diabetic acidosis, daily excretion of 100 to 200 mM. betaoxybutyric acid is common and amounts over 400 mM. have been recorded.[3] In cats, Stadie, Zapp, and Lukens[4] calculated that only 1/7 of the beta-oxybutyric acid produced in the liver was excreted. It has been estimated, therefore, that from 1,000 to 2,000 mM. of hydrogen ion as beta-oxybutyric acid may be produced a day. The body can utilize large amounts of ketones for energy, but the limit is approximately 1500 calories per day.

When plasma pH drops to 7.2, the concentration of bicarbonate drops to less than 15 mEq/l., and Kussmaul respiration develops. These associated facts can be used as a definition of severe acidosis and form a useful limit for consideration of acidosis. Lesser degrees of acidosis need prompt treatment with insulin to arrest and correct the process before it becomes severe.

The ventilatory response to acidosis has been studied carefully by Kety.[5] It is clear from their data that hyperventilation increases until pH reaches 7.0. Below that pH respiratory response diminishes. The respiratory compensation thus diminishes and hydrogen ion accumulates more rapidly in such gravely ill patients. Decreasing respiration in a comatose patient, therefore, is a grave prognostic sign and calls for immediate measures to raise the pH.

Kety, et al.[5] also have studied the oxygen utilization by the brain in patients with serious diabetic acidosis. The oxygen consumption was greatly diminished in the unconscious patient. The cerebral metabolic rate was directly correlated with arterial pH and inversely with the ketone level but was not correlated at all with cerebral blood flow.

There are only two ways that the body can correct the hydrogen ion excess—the oxidation of the organic acids to CO_2 and water and the renal excretion of hydrogen ion. The kidney accomplishes this by exchanging H+ for Na and by the excretion of NH_4^+. The kidney is not at top efficiency, however, as noted by Atchley et al[6] and by Clark et al.[7] Ammonia production is limited by two factors: dehydration and the fact that it takes several days for a normal kidney to reach maximal efficiency in NH_4^+ excretion. Acidosis promotes a loss of Na and Cl., also contributes to a cellular loss of K, Mg, and PO_4. The normal adult kidney excretes from 50-70 mEq. daily of acid as H+ plus NH_4^+. In diabetic acidosis this can increase to 500 to 700 mEq. of H+ per 24 hours. Only about 150 mEq. H+ can be excreted initially since maximal NH_4^+ excretion will not develop for 24 to 48 hours. It should be mentioned that an enormous amount of H+ is generated and removed by cellular respiration normally.

The topics of major concern here are the need for insulin, the water, and the electrolyte loss, and appropriate corrective measures to compensate for this loss. There are three studies of this problem which will be discussed in some detail, since

TABLE 6

Number	Name	Fluids given IV ml/kg	Na mEq/kg	Cl mEq/kg	K mEq/kg	Mg mEq/kg	PO_4 mEq/kg	State of Consciousness
1	JM	148	10	10	5.6	1.2	1.3	4
2	MF	160	10	8	4.0	1.5	3.5	5
3	ML	134	9	8	3.8	1.0	2.3	2
4	LM	101	5.1	4.0	2.1	0.5	1.2	4
5	DK	156	9.6	8.5	2.4			5
6	DP	140	11	10	2.8	0.6	1.4	4
7	EP	37	5.8	5.8				2
8	WS	64	4.7	4.6	1.7	0.3	0.8	3
9	DV	103	8.5	6.7	2.7		2.0	2
10	DV	112	9	8	4.0	0.9		4
11	CF	71	7.5	5	1.4			4
12	CF	67	7	6	1.3			1
13	EC							5
14	HK	66	6.5	6	1.5	0.2	0.4	2
15	LM	23	2.7	2.4				1
16	LM	108	8.4	9	1.8	0.5	0.6	2
17	LM	77	5	3.7	1.2		0.6	5
18	LM	54	5.1	4.6				1

Table No. 6 represents the amounts of fluid and electrolytes per kilogram of body weight given in the first 24 hours of treatment.

these give us the best measurement of the magnitude of depletion in severe diabetic acidosis.

Atchley, et al,[6] in 1933, reported observations on the electrolyte and water losses in a diabetic patient on insulin withdrawal and development of acidosis. Their observations actually can form the basis for rational therapy. Their demonstration of potassium depletion was overlooked for over a decade and the full therapeutic significance of their other findings also was overlooked for an even longer time. Their data are summarized in Table 7 which also shows the findings of two other groups.

TABLE 7

	Atchley	*Butler*	*Nabarro*
Body Size	58 kg	68 kg.	1.73 sq.m.
Water, liters	3.8	6.6	4.6
Sodium and magnesium, mEq.	216		
Sodium, mEq.		322	428
Magnesium, mEq.		50	40
Potassium, mEq.	362	388	339
Chloride, mEq.	42	272	390
Phosphorus, Gm.	4.6	5	1.15

Butler and his co-workers[8] reported similar but more detailed studies in 1947. There is remarkably good agreement with the findings of Atchley. The severity of water loss is not fully appreciated by percentage of body weight but, as Butler emphasizes, the average loss of water actually amounts to 17 per cent of body water.

Nabarro, Spencer, and Stowers[9] carried out balance studies during the recovery phase of diabetic acidosis. Their studies agree with those cited above. Their studies extended over a 10-day period and, therefore, contribute to our understanding both the acute phase and the early convalescent phase. They found that potassium therapy contributed to quicker chemical repair and prevention of excessive storage of sodium. The use of phosphate solutions also appeared to contribute to more rapid recovery of chemical balance. Useful information derived from the above data are recorded in Table 8.

TABLE 8

	Butler	*Narbarro*
Water, ml./kg.	100	80
Sodium, mEq/kg.	5	6
Chloride, mEq/kg.	4	5.5
Potassium, mEq/kg.	6	5
Magnesium, mEq/kg.	0.8	0.6
Phosphorus, mg/kg.	70	15

The evidence cited above will be used as a guide for calculating repair solution needs. There have been a number of reports of hyperchloremia occurring after therapy of diabetic acidosis primarily with sodium chloride solutions. There are sound reasons for giving hypotonic solutions with a ratio of Na/Cl of more than 1.0—as a matter of fact it makes sense to give solutions with ratio about 1.2:1.0. The cumulative losses approach this ratio. Simply by adhering to the principle that it is wise to correct any deficit which has developed, the use of potassium, phosphate, and magnesium salts in addition to sodium salts is warranted. The serious clinical manifestations of hypopotassemia during course of therapy of diabetic acidosis were reported by Holler,[10] in 1946.

The following pattern of therapy has proved to be simple and effective for adults. There is a relatively greater need for free water in children and, of course, amounts of electrolytes need to be calculated on a weight basis.

Liter	*Na*	*Cl*	*HCO_3*	*K*	*PO_4*	*Mg*	*SO_4*
1	133		133				
2	121	77	44				
3	77	117		40		16	16
4	77	77		40	40	16	16
5	77	77		40	40	16	16
	485	348	177	120	80	48	48

These solutions are made up as follows:

Liter

1. 1000 ml. + 3 ampules $NaHCO_3$ (44.5 mEq/ampule)
2. 1000 ml. ½ strength saline + 1 ampule $NaHCO_3$
3. 1000 ml. ½ strength saline with 5 per cent of glucose, 40 mEq. of KCl, and 2.0 gm. of Mg SO_4 (4 ml. of 50 per cent solution) (16.3 mEq.)
4. 1000 ml. ½ strength saline with 5 per cent glucose + 40 mEq. of KH_2PO_4 + K_2HPO_4 and 16 mEq. of $MgSO_4$
5. 1000 ml. ½ strength NaCl. with 5 per cent + 40 mEq. (KH_2PO_4 + K_2HPO_4) + 16 mEq. $MgSO_4$

Such a regimen will supply enough water and electrolytes to compensate for the average losses of most ions and water, with the exception of potassium. It is not necessary and usually not wise to correct completely the potassium deficit in the first 12 hours. The usual rules about safety of administering potassium such as infusion of 20 mEq. per hours, knowledge that urine is being formed, the maximal safe concentration of 80 mEq./l., are important. The serum potassium often is increased initially, so potassium should not be given with first fluid administered unless a normal potassium has been demonstrated.

Approximately the same goal can be reached by using certain ready-made solutions, but with certain disadvantages. The first two liters could be Ringer's lactate solution and the next three

liters could be either Baxter #2[R] solution or Abbott D[R] solution. If Baxter #2[R] or Abbott D[R] solution is used, potassium phosphate or chloride (20 mEq) and magnesium sulfate (8.1 mEq. or 1 Gm.) should be added to each liter.

After this amount of fluid usually oral fluids are tolerated. If not, additional glucose in distilled water with potassium salts added is indicated until a total of 7 liters or more is given.

The recommendations of optimal insulin dosage by Smith and Martin[11] are reasonable. An initial dose of 80 units of unmodified insulin can be given subcutaneously or half intravenously and half subcutaneously. This dose should be repeated in an hour. A glucose determination at two hours should be obtained. If the blood glucose has fallen 20 per cent or less at two hours the dose of 80 units should be repeated. If it has fallen 20 to 30 per cent but not below 300 mg. per 100 ml., a dose of 40 units should be given. If the sugar has fallen below 300 mg. per 100 ml., 5 per cent glucose should be added to the infusion and 25 units should be given for each 50 Gm. of glucose administered. If the sugar has not fallen or has actually risen, as occurs in patients with insulin resistance, it is important to double the dose and follow the blood sugar every hour. If it still does not fall, it is necessary to give massive doses of insulin every hour until the glucose falls.

The need to find out what happens to the blood sugar and acetone cannot be overemphasized. This is one important reason for not administering glucose initially. This is far more important than urine tests. If the patient is comatose, an indwelling catheter is needed to prevent overdistention of the bladder, but if the patient is conscious, a catheter should not be used. A catheter must be removed just as soon as the patient is fully conscious. It is much better to do a few extra blood glucose determinations than to run the serious risk of urinary bladder infection.

Shock which does not respond to initial parenteral fluid therapy, calls for infusion of a plasma volume expander. Vasopressor agents may be needed but should not be used until a plasma volume expander has been used. Hydrocortisone phosphate in large dose (such as 500 mg.) partly intravenously and partly intramuscularly might be needed in addition to the above. This may have a delaying action on recovery from acidosis, but hydrocortisone may prevent shock from becoming progressive or irreversible.

If oliguria develops, there must be modification of fluid therapy. Potassium should be given only if the serum level drops below 2.5 mEq/l. and then only with careful monitoring. Usual measures for oliguria will be needed after dehydration has been reasonably well corrected.

Myocardial infarction and heart failure may be complicated by acidosis. Fluid therapy often needs to be limited to a total of two liters or less in a 24-hour period. If edema is present, no electrolytes should be administered except potassium as determined by actual measurement. Insulin needs usually are less and may be only treatment needed. Hypoglycemia must be avoided.

Infection or gastrointestinal upset may precipitate acidosis and needs appropriate treatment. Careful examination for infection of ears, nose, throat, lungs, urinary tract and meninges are a particularly necessary part of every initial examination.

The prognosis of diabetic acidosis has been the subject of analysis and mathematical formulation. Unfavorable prognosis is correlated with B.U.N., duration of coma, degree of unconsciousness, but not with blood sugar or CO_2.[12] The prognosis has improved progressively as a result of recognition of physiological factors, need for large initial doses of insulin, more accurate care of fluid and electrolyte needs (especially potassium) and effective treatment of associated infections.

In the clinical experiences recorded above, the amounts of Na, Cl, and water exceeded the theoretical needs in most instances. No attempt was made to do balance studies, so an excess over theoretical amount usually was given in order to insure sufficient quantity. Apparently no harm results from modest excesses of sodium and chloride since renal excretion of the excess occurs.[9] Nevertheless, an excess which equals or exceeds the calculated need cannot be considered to be good for the patient with any impairment of renal or cardiovascular function. A reasonable aim, therefore, should be an excess over theoretical need of about one-half the theoretical need.

Summary

Eighteen episodes of diabetic acidosis of varying severity were treated in the West Virginia University Hospital from 1961 through 1964, and the total amounts of insulin, fluids and electrolytes given during the first 24 hours are reported. Four cases are reported in detail. Precipitating

factors, the state of consciousness at the beginning and during treatment and the amounts of insulin, fluids and electrolytes given during the first 24 hours are described.

The rationale and the principles of treatment of diabetic acidosis are discussed, particularly in regard to the insulin needed and the replacement needs of fluids and electrolytes.

The importance of the prompt quantitative replacement of the calculated losses and large doses of insulin early are emphasized to insure the complete and quick recovery from the acidotic state. A practical form of treatment is presented.

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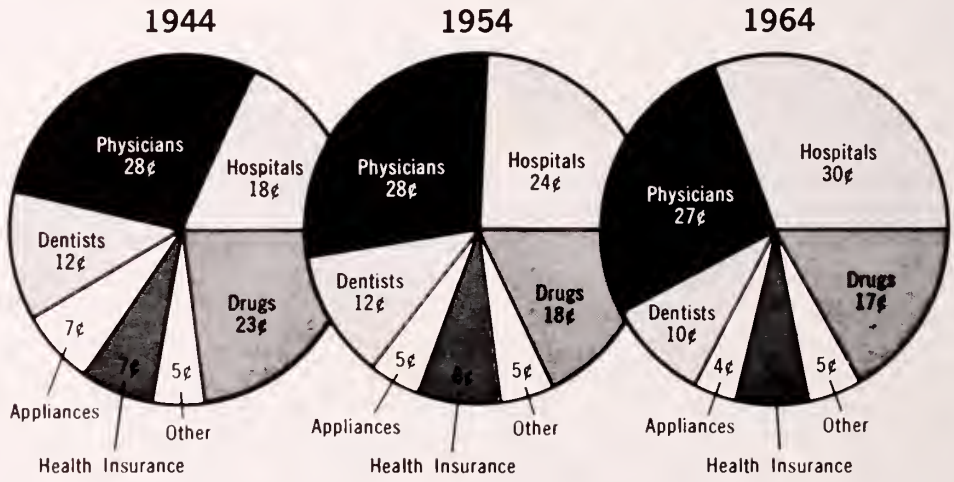

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—AMA News Graphichart

Insect Sting Allergy and Its Management*

Claude A. Frazier, M. D.

HYMENOPTERA form one of the largest and most highly developed orders of insects. Estimates of the number of different species exceed 100,000 but there are undoubtedly many others which remain to be discovered or correctly identified. Included in the order are bees, wasps, hornets, yellow jackets, ants and sawflies.

The term "Hymenoptera" stems from the Greek for "membrane" and "wing"; these insects, therefore, are membrane-winged. They are of great interest not only because of their perfect structure but because of the remarkable development of their instincts, also because of their profound effect on other forms of land life.

Beneficial effects of Hymenoptera include the subterranean activity of ants which loosens, aerates and mixes the soil; the production of seeds by the vast number of plants which are pollinated by bees; the hordes of plant eating insects which are naturally checked by the parasitic wasps. Represented by this order are perhaps the most widespread, pervasive and diversified members of the insect world.

The tubular ovipositor has lost its original function in some bees, wasps and ants and has become instead a stinging apparatus. This modification of the egg-laying tube enables it to function as an effective weapon for offense or defense. The sting issues from the apex of the abdomen and is withdrawn into the body when not in use. The presence of an ovipositor serves to identify the female insect since the sting is absent in the male.

The stinging or aculeate Hymenoptera are divided into two distinct groups: those which kill their prey by stinging and those which seek only to paralyze prey in order to facilitate the return to the nest with the prize and to keep the specimen in fresh condition until larvae are ready to eat it. Apparatus in those which kill is more complicated since it possesses both an acid gland and an alkaline gland. It is the combination of these acid and alkaline fluids that results in the death of an attacked insect or causes extreme pain. Severe reactions or even death may result in man if there exists an allergy to the offending insect.

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Stinging Hymenoptera which have been found responsible for allergic reactions in man are contained in the superfamilies Apoidea (bees), Vespoidea (wasps, hornets and yellow jackets), Sphecoidea (solitary wasps) and Formicoidea (ants).

Bees

It is a common belief that the social bees such as the honey bee and the bumble bee are the most numerous. In fact, however, they are very much outnumbered by the solitary bees. There are approximately 10,000 different species of bees known but only about 5 per cent are repsented by the social varieties.

Solitary Bees.—The term, "solitary," signifies that each female prepares her own nest, provisions it with nectar and pollen, and lays an egg, without additional concern for the future development or welfare of her offspring. The larvae eat the provisions supplied by the mother, pupate, and in time emerge as adult bees. They survive only one season in contrast to the social bees in which the colony overwinters.

Although solitary bees do assist in the pollination process, they visit flowers only on a need-of-the-moment basis and therefore are not of the same economic and agricultural necessity as the social bees.

Of the many thousands of solitary bee species, the most common are the carpenter, leaf cutter, miner, mason and cuckoo bees. They do possess stings and some do sting man but the results are usually mild. Serious cases of bee-sting envenomization usually are due to the social bumble bee or honey bee.

Social Bees.—The term "social" signifies that these bees live in well-organized communities. There are different castes of bees, each one having specific assignments or duties which serve

to improve the efficiency and productivity of the colony.

The most primitive of the social bees is the bumble bee while the most highly organized are the honey bees.

Bumble Bees.—The bumble bees belong to the family Bombidae. Two hundred or more varieties have been identified and are characteristic of temperate regions the world over.

Bumble bees are particularly feared because of their large and burly appearance, noisy buzzing flight from which their name stems, and their long sharp stings. These bees, however, are not as vicious as the honey bee but occasionally the unwary farmer or hiker may disturb a nest and provoke attack.

Bumble bees generally are happy-go-lucky insects and take life as it comes without any of the severe discipline of their cousins, the honey bees. They do have enemies which include certain beetles, flies, ants, mites, wasps, birds and skunks but man probably is their greatest enemy since insecticides do away with the insects, and cultivation of the soil destroys their nests.

Honey Bees.—These bees are considered much more valuable in fertilizing crops than in producing honey. Some 50 seed and fruit crops depend on the honey bees or yield more satisfactorily because of their presence. A colony containing 60,000 or more workers would provide an estimated 37,000 loads of nectar to make a pound of honey, but if each bee in the colony made only ten field trips each day, some 300,000 flowers would be visited.

Living and working together in these large and well organized communities or colonies, a group of honey bees can go on for many years while a single insect would last only a few days. There are three different castes or classes found in each colony; the queen lays the eggs, the workers gather food and care for the young and the drones fertilize the queen. These three groups are dependent upon each other. Although the queen does not truly rule the colony, she is the force or stabilizing influence which holds it together and the workers become confused and disorganized if she is not in the nest.

The female honey bees possess stings but the queen uses hers only when a younger queen has ambitions to replace her and a till-the-death battle ensues. The worker bees, however, by virtue of their number and activities outside of the colony, most frequently sting man since they are the guardians against enemies as well as being builders, food gatherers, nursemaids and housekeepers.

Wasps

Thousands of species of wasps occur within the United States and at least 50 varieties are troublesome pests about residential areas, public picnic facilities and orchards. As in the case of bees, there are both social and solitary wasps. The important difference is that the social wasps usually are more abundant and therefore present a greater hazard to man since they are particularly aggressive in the vicinity of their nests.

In spite of published reports concerning wasp stings, it is not possible to say which species most often cause serious reactions in man. Many wasp identifications are doubtful since they are based on descriptions provided by the victim who quite often cannot accurately distinguish one species from another. Polistes, however, also hornets and yellow jackets probably are the members of the wasp family most frequently involved because of their well established aggressiveness; yellow jackets also seem to have a propensity for gathering in areas frequented by man.

While it is true that some wasps attack and destroy large numbers of domesticated bees and others injure trees with their gnawing, the wasp population as a whole does man a decided service by annually destroying large numbers of harmful bugs, beetles, caterpillars and flies.

Solitary Wasps.—These insects primarily are hunters, with each species tending to specialize in a certain prey, disregarding others of similar size and color. Many formidable stingers such as ants, bees and other wasps are taken as prey, together with grasshoppers, crickets and spiders.

The tarantula killer is particularly interesting since the tactics used by this wasp are very clever. It induces the spider to rise in self-defense on its back legs. As it does so, the spider exposes a vulnerable spot on its breast. With a quick thrust of the stinger, the wasp disables the spider. This prey has been known to remain alive but motionless for more than five weeks after an attack of this type.

Social Wasps. — Social wasps are primarily predaceous and feed upon other insects but they are also quite fond of nectar, over-ripe fruit or honeydew. These wasps are the paper makers of the insect world. They build large nests in which many insects live, and have castes similar to the social bees. Since the most common wasps are inhabitants of the north temperate zones, all members of the nest perish with the cool weather except for an annual brood of queens which, after fertilization, hibernate and found new colonies in the spring.

Hibernating wasps are roused to activity by the warmth of early spring weather and search for suitable nest sites. Some species build in the open, attached to branches, under a porch or beneath any projecting surface. Others build underground. Occasionally, a queen may use a nest built by other wasps during a previous year.

Yellow Jackets.—These are small wasps with black and yellow stripes which are closely related to hornets. Their nests are made of paper and are usually several stories of cells inside a thick paper envelope. The family may reach several thousand insects to each nest.

Locations of the nests vary; sometimes they hang from trees or bushes; sometimes they are in ground holes dug by field mice or gophers; and sometimes they are contained in hollow stumps or stone walls.

The most common yellow jacket species is Vespula vulgaris. These wasps are often mistaken for honey bees but they are smaller and more decidedly yellow in color. They are quite aggressive and well known for their quick tempers and easy provocation. They bite just prior to stinging and so add insult to injury. Since only queens and workers possess the efficient stinging apparatus, a ready identification symbol is found in face coloration: the male wasps have white or yellow faces while the females have black faces. Yellow jackets are commonly seen in areas which provide their preferred foods; in orchards, for example, they are particularly hazardous since they become intoxicated on fermented fruits. They eat all vegetable matter and soft-bodied insects and are particular pests about garbage cans or picnic areas where these foods are readily available.

Hornets.—Adult hornets ordinarily feed on the nectar of flowers but they will take almost any available foodstuff in liquid form. Insects or caterpillars are gathered for the brood at home; they are not stung but are butchered alive and dismembered to facilitate removal to the nest site.

Hornets are usually black or dark brown with yellow markings. They build the large, grey, football-shaped nests which often are seen hanging from the branches of trees or shrubs. The outside of the nest is composed of many layers of water repellent paper. Sometimes the diameter is as much as 12 inches and the nest may contain as many as 10,000 citizens which pour out in large droves at the slightest threat to the colony.

Polistes.—These paper wasps are elongated and slender with a spindle shaped abdomen and usually are reddish or brown in color. Their nests consist of a single more or less horizontal comb of paper cells which are exposed at the bottom surface. These nests are commonly seen under eaves or windowsills to which they are attached by a slender stalk. Although the nests are not as large as those of hornets or yellow jackets, during a season they may reach 6-8 inches in diameter and house several hundred insects.

It is indeed fortunate that Polistes are not aggressive since they are commonly found in, on or near houses and outbuildings. These wasps do sting but only on the greatest provocation and, although the sting is painful, it in no way is comparable to the harmful effects caused by yellow jackets or hornets.

Stinging Apparatus

There is little variation in the venom apparatus of the stinging Hymenoptera. In bees, wasps, hornets and yellow jackets the females are provided with a specialized ovipositor which is more or less well adapted to pierce the skin of higher animals or other insects and thus may be used for offense or defense. It consists of three parts: the piercing apparatus, the lateral plate and appendages, and the poison sac and glands.

The sting usually lies hidden inside a cavity of the tip of the abdomen from which it is extruded when the insect is ready to attack. It is usually a hollow needle split longitudinally into three pieces which together surround the poison canal. This canal communicates with the poison sac. The venom glands lie under the terminal abdominal segment.

In the bee, the stinger is barbed and contractions thrust the stinger deeper and deeper into the flesh where it becomes anchored with the barbs. Withdrawal is impossible; in the struggle of the bee to escape or in the victim's attempt to brush the insect off, the whole stinging apparatus is usually avulsed and the bee dies.

The wasp sting, however, is not barbed so that it is withdrawn at will and the insect can either escape or can return to sting again. It is therefore unusual to find a wasp sting left in the wound.

Venom

Several potent pharmacological substances have been identified in the venom of Hymenoptera. Electrophoretic, chromatographic and fractionating techniques are largely responsible for our current knowledge concerning the chemistry of these venoms but the exact chemical composition is as yet undetermined.

Bee venom is thought to contain histamine and release histamine from the tissues. Amino acids,

cystine, histidine, methionine, phenylanine, tyrosine and the enzymes hyaluronidase and phospholipase have all been identified[1].

The spreading factor, hyaluronidase, is also present in wasp venom having been found in hornets, Polistes and yellow jackets. Wasp venom also distinctively contains 5-hydroxytayptamine and free amino acids[2]. Venom of the hornet contains a surprising amount of acetylcholine which has also been found in the venom of Polistes[3]. A potent hypotensive agent, designated kinin, has been found in the venom of V. vulgaris. The action of this polypeptide resembles other polypeptides but some properties appear to differ[4].

Immunology

Bee, wasp, hornet and yellow jacket venom contains from four to six antigenic fractions. Probably two of these are immunologically identical and the other two to four are characteristic of individual insect species and not shared by other species[5]. Patients who have had an allergic reaction to insect stings may have skin test sensitivity or hemagglutinating antibodies against one or several of the insects of the Hymenoptera order[6].

Loveless[7] has reported a common antigenicity between wasp and yellow jacket. She has shown[7] that patients immunized by progressive stings with yellow jackets will be protected not only from subsequent stings from the same type of insect but from wasp stings also. The reverse also was true. Injections of emulsions of wasp venom or stings by wasps were able to protect not only against reactions from wasp stings but from stings by yellow jackets.

Loveless and Fackler[8], using both *in vivo* and *in vitro* techniques, attempted to determine the relative responsiveness of a group of wasp-allergic patients to different Hymenoptera venoms. They concluded that an individual sensitized by the yellow jacket would be susceptible to the sting of the hornet as well as to Polistes venom since each appeared capable of obliterating the challenge response to yellow jacket allergen. The same situation was encountered for the honey bee which carried in its venom all the activities characterizing the yellow jacket plus additional ones peculiar to itself.

Important activity in the bumble bee venom, on the other hand, appeared to be unrelated to any of the other venoms except the honey bee. It would not be anticipated, therefore, that the yellow jacket-sensitized patient would be comparably or invariably susceptible to bumble bees. One would surmise, however, that the honey bee-allergic patient would be adversely affected by the bumble bee since the honey bee's venom is capable of forestalling at least partially the challenge activity of the bumble bee venom. There are several indications that all the venoms contain some antigens in common.

Type of Reactions

Hymenoptera stings may result in a variety of symptoms, depending upon the amount of venom injected, the absence or presence of sensitivity and, to some extent, the site of the sting.

A single sting may cause minor discomfort or may cause death in a sensitive individual. Symptoms may last for only a few hours or may persist for days. They may occur within seconds or a few minutes of the sting but may not be apparent until several days have past. Subsequent stings may cause reactions of diminishing intensity due to naturally acquired immunity (as reported in some bee keepers, for example) or may produce sensitization. It is indeed difficult to predict which symptoms may be produced by subsequent stings when such an allergic state has been provoked.

In general, however, most stings produce symptoms that may be classified as: (1) toxic reactions—resulting from multiple stings which, even in the absence of sensitivity, provoke serious disturbances which may result in death, (2) local reactions—occurring approximate to the sting site and (3) systemic reactions—perhaps resulting in anaphylaxis.

At the time that the sting is inserted and pierces the skin, there is a sharp pin prick followed by pain which lasts for several minutes. The degree of pain experienced is usually slight but may be severe. Within a few minutes a small red area appears at the sting site and is gradually surrounded in turn by a whitish zone and a reddish flare. A wheal then forms and, as it subsides in a few hours, it gives place to irritation, itching and heat. All trace of the sting usually disappears within 24 hours. This then is the usual response.

Toxic Reactions.—Occasionally a swarm of bees or wasps may attack and the amount of venom injected into the victim may cause systemic poisoning. The clinical findings in these instances resemble those of generalized allergic reaction but there is a greater frequency of gastrointestinal upsets with diarrhea, vomiting, faintness and unconsciousness as the principal symptoms. Recovery from the severe effects of these mass onslaughts usually takes place within 24 hours. Although death has followed when some 500

or more stings were inflicted, there are reports of survival following more than 2,000 stings[9].

Case Report

J. R., aged 30 years and an European male, had gone to look for an African who had been attacked by bees the previous day. He was walking along a river bank when without warning or provocation, a swarm of bees attacked and covered the upper half of his body in a layer about three inches thick. They began to sting him and he felt an intense burning sensation as though he were on fire. He dived into the river and must have lost consciousness for his next recollection was of finding himself standing in backwater, without his shirt, vomiting and having diarrhea so persistent that he was incontinent and the bees were still upon him and around him stinging repeatedly.

He moved towards deeper water, sat down and put his shorts over his head to try to protect himself but the bees continued to sting him through the material. He then plastered his shorts with mud but every time his arms came above the water to do this he received more stings. He eventually completed this task but had to leave a hole for air which the bees found. When they landed to sting, he tried to brush them away but this exposed more of him to be stung and he found that the best thing to do was to keep his mouth close to the hole and bite the bees with his teeth. Many of these bees he had to swallow and he maintained that they passed right through him.

Throughout this time, he was suffering headache, diarrhea and a continuous burning pain in his stomach but at no time did he have any trouble with respiration.

He was in the water for about 4½ hours before he was found at dusk, the bees having dispersed. On examination, he was shocked, cold and looked exhausted. The face, neck, scalp and trunk and the upper limbs were black with stings and the hair matted with dead bees. There was considerable facial edema, and the pulse was rapid and thready. He complained of great weariness and of his body burning. He begged for water but, on drinking, immediately vomited, only to crave more.

He was given 100 mg. hydrocortisone intravenously and then 100 mg. pethilorfan slowly. Towards dawn he complained that the stings around his eyes and mouth were painful and 221 stingers were removed from the eyelids, lips, and inside of the mouth without deterioration in his condition.

He made an uneventful recovery, being discharged five days later. The possibility of allergy to bee venom after this incident was considered but skin testing was negative up to a dilution of 1:10 and he was later accidentally stung without suffering any generalized effects.

Yet another interesting case report has been published concerning an 18-month-old male infant who received 477 wasp stings[10]:

Case Report

M. B. was admitted to an Emergency Department one and one-half hours after being stung over most of his body by a swarm of wasps. At the time of admission, there were still 10 live wasps in his clothing but, by actual count, it was found that he had received 477 stings.

On admission, he appeared to be in great agony, rolling and thrashing about in bed. His eyes were completely closed due to facial edema. The skin was edematous and covered with dark red pin-point spots. Temperature was 104 F., pulse 130, respiration 40; blood pressure could not be determined.

He was given phenobarbital sodium, benadryl, adrenalin and codeine phosphate. ACTH therapy was instituted eight hours after admission. Four days later the patient was considerably improved; the edema was subsiding and he was able to take a soft diet. He remained perfectly well after discharge. In restrospect, it was decided that ACTH did not affect the course of this toxic reaction but that it was wise to institute the drug early in the possibility of its future need.

Local Reactions.—These reactions may consist simply of an unusual amount or duration of swelling, or both. Any degree of swelling, even if an entire limb is involved, is considered to be a local reaction if it is continuous with the sting area and no symptoms are evident at areas distant to the sting.

A complication of this local reaction is infection. It may be presented as a cellulitis which develops some hours or days after the sting. Leadman[11] has recorded the death of a young man from cellulitis of the cheeks, jaw and neck nine days after he had been stung by a wasp on the right side of the neck. A woman also died of septicemia and cellulitis of the throat eight days after being stung in the throat by a wasp. Mease[12] has reported a man who died 27 hours after a wasp sting on the left side of the throat. Tracheotomy had been done and it appeared that the swelling of the throat was due to infection rather than hypersensitivity.

Should the sting site be around the eyes, nose or throat then the local reaction obviously may cause more than the common amount of distress. Stings on or about the eyes are particularly hazardous since marked local reactions may result in atrophy of the iris, anterior capsular cataract, abscess of the lens, perforation of the globe, glaucoma and change in refraction. The eye may be injured primarily or may be affected months or even years later by a sting working its way through the lid. Stings are probably never absorbed by the tissues and Dorff[13] found one patient having retained a sting which remained unchanged after seven years. Orendorff reported a 25-year-old patient who, three months before being examined, had been stung by a honey bee on the upper lid. The patient had conjunctivitis and, later, kerato-iritis developed. The tip of the bee sting was finally found around the center of the tarsal conjunctiva. After it was pulled out, the patient completely recovered.

Systemic or Generalized Reactions.—The toxicity of the venom of these insects is not great enough to account for the severe generalized reactions which are being reported with increasing frequency. Neither the time interval between the current and the last previous stings nor the frequency of stings appears to be related to the severity of reaction. Although there may be a history of successively worsening reactions, many patients may report no previous reaction to a sting before the present severe reaction suddenly develops.

These reactions generally occur within a few minutes of the sting although delayed reactions can occur 24 hours or even 10 days later. In the latter instances, the mechanism is considered to be similar to that of serum sickness and symptoms may consist of painful joints, swollen glands, fever or generalized urticaria, or both.

Generalized papular urticaria has been reported but urticaria of the usual variety is a frequently observed symptom in generalized reactions. Marked regional adenopathy consistently follows stings in some sensitive individuals. Petechial hemorrhages (locally, generally or subcutaneous or distributed throughout many organs) have been observed even in the central nervous system.[14]

The more severe reactions consist of one or more of the following: constriction of the throat and chest, dyspnea, asthma, cyanosis, abdominal cramps, diarrhea, nausea, vomiting, chills and fever, vertigo, laryngeal stridor, shock, loss of consciousness, involuntary bladder and bowel action, and bloody, frothy sputum. There also have been reports published of strings causing coronary thrombosis[15], hemiplegia[16], neuritis[17], the nephrotic syndrome[18] and encephalopathy[19].

Case Report

A 44-year-old man was brought into the emergency room following a wasp sting. Immediately following the sting he attempted to walk to the bathroom and lost consciousness; his eyes "turned back into his head" and for a few seconds he had a generalized convulsion. He became bluish and received mouth-to-mouth resuscitation from his son for five to ten minutes. He remained unconscious for about an hour and was given oxygen in the ambulance en route to the hospital.

On arrival, blood pressure was 60/30, pulse 120, respiration 18 and temperature 100 F. rectally. The patient was responsive but somnolent; he would answer questions but at times rather poorly.

In the emergency room he was given epinephrine intravenously and 10 mg. of mephentermine (Wyamine) intramuscularly, oxygen by mask; 200 mg. of hydrocortisone (Solu-Cortef) intravenously and promethazine HCl (Phenargen) 45 mg. intramuscularly. The blood pressure improved. He subsequently complained of severe, intense pain in the thighs and upper legs which required meperidine HCl (Demerol).

Following admission, the patient gradually improved. He had considerable indigestion, gaseous sensations in the abdomen and some substernal burning which he stated was similar to that which he had had in the past. A myocardial infarction was suspected because of one electro-cardiographic tracing but later the changes were thought to be most likely the result of tissue anoxia rather than myocardial damage.

Desensitization was started and after he had received about nine injections of extract he was again stung by a wasp early one morning. Naturally terrified, he rushed to the office but as he was observed in the office he had no reaction to the sting.

Numerous fatalities have been reported and frequently are given dramatic coverage in the public press. Necropsy findings have shown the following in order of frequency: pulmonary emphysema, cerebral edema, fatty metamorphosis of the liver, dilatation of the heart, epicardial hemorrhage, fluid blood, congestion of the nasal sinuses, cerebral petechiae, meningeal hyperemia, fatty degeneration of the heart, cardiac hypertrophy and lobar pneumonia.

Incidence of Local and Generalized Reactions

The Insect Committee of the American Academy of Allergy has reported[20] the following analysis of 2,606 persons allergic to insect bites or stings who are listed in a registry compiled by the Committee over a three-year period. Of these registrants, 347 reported local reactions only while 2,206 experienced generalized reactions. Six hundred thirty of the latter group were life-threatening in degree or intensity. Delayed reactions, with no immediate local or systemic signs, were reported by 73 registrants; many persons had both immediate and delayed reactions to the same sting.

One important finding in this analysis was that generalized reactions often occurred without a previous unusual reaction to a sting. In fact, 83 persons recalled no previous stings and 303 had been stung either with no reaction or, at the most, only a local reaction resulting. About one-third of the registrants had a past personal history of other allergies but severe reactions did occur in others with negative personal or family histories.

The author[21] recently completed a study on 78 pediatric patients, all of whom had experienced insect sting reactions, to determine whether there were characteristics peculiar to those persons having generalized reactions in contrast to those having local reactions.

The children were divided into two groups; one group consisted of 29 individuals who had experienced large but local reactions, with swelling, several inches in diameter, confined to the area around the sting site; the other group consisted of 49 persons experiencing one or more of the symptoms characterizing general reactions.

These patients ranged from 2 to 16 years of age. Twenty-nine, or 37 per cent, were between 5 and 8 years of age. It is believed that children under two years of age are stung less frequently since they usually are under close and protective maternal observation, while those between 5 and 8 years, normally aggressive and inquisitive, are more likely to tantalize stinging insects. In this study, 50 patients were male and 28 were female. Thirty-one males had generalized reactions and 19 had local reactions; 16 females had generalized reactions and 12 had local reactions. There were, therefore, almost twice as many males having generalized reactions. Sex and age factors in the incidence of severe reactions suggested increased vulnerability in preadolescent males while the younger children had more local reactions and less severe generalized reactions.

Factors relating to the type of insect and the site of sting also have been considered in both the Insect Sting Committee study and this Pediatric Study. The honey bee and the yellow jacket were most frequent offenders. It is important to realize, however, that even the best informed parents and children are subject to error where accurate and positive identification is concerned.

In a previous study both of pediatric and adult patients, I found that the head and neck, followed by the feet, were the most frequent areas to be stung.[22] In the children's group, however, there was a higher incidence of stings on the feet. This is presumably due to the childhood practice of going barefoot in summer.

Although stings can and do occur occasionally during the cold weather months (for example, when a Polistes wasp is disturbed in the attic or interior hibernation place), Hymenoptera stings occur most commonly during the summer. July and August are the peak times of insect activity; they also account for the greatest number of stings. Most generalized reactors in the pediatric study were stung during July.

Is it possible to predict which persons are most likely to be stung and which type of reaction might ensue? In correlating the data obtained from the two groups of pediatric patients, we noted the following outstanding characteristics:

The sting-prone child is a white male between 5 and 8 years of age, who is outside playing on the lawn or near flowers. He is barefooted and bareheaded and is dressed in gaily colored and rough fabric clothing. Sweet-scented hair oil keeps his wayward locks in place. Excess energy is being expended in locating a honey bee and chasing it about the garden in an attempt to capture it.

A local reaction might be anticipated in a colored or white preschool child who has kept his shoes on but is stung on the arm during July by a yellow jacket. He has a history of nasal and penicillin allergies and there is a family history of various other allergies. Preceding stings, averaging one each year, have resulted in a local reaction also.

A generalized reaction is most likely to occur in a teenaged white male who perhaps has a family history of allergies but is not necessarily allergic himself. He also has averaged one sting each year, resulting in no difficulties. He steps on a honey bee or hornet during July and has a generalized reaction which has both his parents and him concerned for the future.

It is realized that these characteristics might not hold true if a larger number of cases were analyzed. Although we cannot accurately predict which patients might experience what reactions, this pediatric study does help to identify the reaction suspect or prone patient.

Diagnosis

The identification of the offending insect is an important clue in initiating correct therapy and suggesting appropriate preventive or eradicative measures. The specific insect also determines which insects are used in extracts for immunization procedures.

Some basic knowledge of the insects common to the area, together with information concerning their habits will, when added to the history and clinical findings, help to pinpoint the type of insect involved. For example, knowledge that the honey bee leaves the sting in the wound while members of the wasp group do not is most helpful. Wasps are abundant about house, garbage cans and lawns while bees are more common to flower beds or forests. Yellow jackets most frequently nest in the ground while hornets nest in trees or shrubs and Polistes congregate under eaves or windowsills.

When confronted with a possible delayed reaction, it is most important to inquire whether a sting has been received during the last few days. Most patients will not associate the present symptoms with an insect sting received several days before.

Treatment

The onset of symptoms becomes more rapidly progressive with the increasing severity of the reaction. The shock reaction noted in highly sensitive individuals becomes apparent, on the average, within five minutes of the sting. Prompt classification of the type of reaction and the institution of treatment can be life-saving when a severe reaction occurs.

Local Reactions.—In patients having only a slight local reaction, medication is of limited usefulness. Treatment of the sting site will reduce the amount of swelling and induration and the duration of symptoms in more severe local reactions.

Residual parts of the insect should be removed. If the venom sac has been deposited with the stinger (as in bee stings) it should be removed by scraping off with the fingernail or knife blade since squeezing or grasping with the fingertips will result in more venom being injected.

The early use of ice packs, together with rest and elevation, if an extremity is involved, may reduce the intensity and duration of the swelling. Heat should be avoided. Exercise or dependency will only accentuate or prolong the edema and discomfort.

In some cases of urticaria about the sting site, oral antihistamines may relieve the pruritis and some of the swelling. Oral or parenteral steroids are given when the reaction is considered excessive and distressing, or when it is protracted and resistant to rest and ordinary measures.

Generalized Reactions.—Since the generalized reaction may range from a few urticarial lesions to generalized angioedema, or from syncope to profound shock, the type of treatment obviously must be adapted to the nature and severity of the symptoms. Since the onset and fulmination of symptoms are extremely rapid, these situations demand prompt and energetic treatment.

The physician will not be present at the moment of sting and usually is not in attendance until some time after the generalized reaction has developed. Therefore, the patient who is suspect must be supplied with medications for use during the initial stages of such a reaction and should be advised to start treatment immediately and to seek prompt medical attention.

The milder symptoms may be relieved by ephedrine or isoproterenol (Isuprel). A 15 mg. tablet is prescribed for adults and half a tablet for older children. An oral antihistamine such as Dimetane, (4 mg. for adults and one-half tablet for children) also is recommended. It is wise to suggest that these patients have available epinephrine HCl aerosol (such as Epihaler) or Isuprel HCl aerosol (Isuprel mistometer) for inhalation. Various insect sting kits are available or may be prepared, containing epinephrine either for injection or nebulization.

When the sting occurs on an extremity, a tourniquet should be applied above the sting site and between the site and the body. This will slow down the rate of venom absorption. The tourniquet should not be too tight and the pulse at the foot or wrist should still be detectable while the tourniquet is in place. The tourniquet should be loosened every three to five minutes and removed as soon as symptoms are brought under control by the medication.

These self-help measures may be sufficient to control the reaction and, even more important, make it possible for the victim to reach medical help should more heroic measures prove necessary.

When the physician is confronted with a patient at this stage, aqueous epinephrine 1:1000, in

a dose of 0.3 to 0.5 cc. for adults and 0.2 to 0.3 cc. for children, should be given by deep subcutaneous injection with the injection site massaged vigorously to hasten the rate of absorption. The patient must be closely observed since his response will determine whether or not the dose should be repeated in 20 minutes or so. Epinephrine is short acting and the patient may slip back into shock as the effects of the first dose wear off. If bronchospasm develops in spite of epinephrine, aminophylline should be given intravenously and slowly.

The epinephrine injections are followed immediately by intramuscular antihistamines. Chlorpheniramine maleate (Chlor Trimeton, 100 mm. per cc.) 0.05 to 0.1 cc.; diphenhydramine (Benadryl, 50 mg. per cc.) 0.5 to 1.0 cc.; and tripelennamine (Pyribenzamine, 25 mm. per cc.) 0.5 to 1.0 cc. are all useful.

If it is necessary to hold and prolong the effects initiated by these measures, it may be helpful to give steroids by intravenous drip, such as Solu-Cortef 100 mg. Adrenal corticosteroids will have little effect during the most crucial stages of reaction and should be used only to supplement the major therapeutic measures.

Oxygen administration will minimize the development of hypoxia which may itself contribute to vascular collapse and cerebral edema. In the severe reactions in which cardiovascular collapse rapidly ensues, measures to support blood pressure and circulation are mandatory. Aramine or Levophed may be given. A cut-down may be necessary to ensure continuation of IV therapy for more protracted effects. Occasionally (especially when massive urticaria and angioedema have developed), plasma expanders may be required to maintain adequate blood volume and cardiac output.

When these measures have been instituted and the patient has responded satisfactorily, the situation is under control and, barring complications, the patient may return home within a few hours.

Delayed Reactions.—It may be necessary in these instances to continue steroids and antihistamines for several days. Dexamethasone can be given, beginning with two 0.75 mg. tablets three times a day, with the dosage gradually reduced according to the response of the patient. Oral antihistamines such as Dimetane, 4 mg., four times a day, are recommended for adults, and half a tablet for children.

Long Term Management

Once the immediate emergency situation is over, steps must be taken to provide future protection for the patient. It is wise to recommend that these patients carry on their persons at all times a device (such as dog-tag, bracelet, locket or ID card) which gives information concerning their allergy to insect stings and recommends first aid measures. This symbol might prove invaluable if such a patient is found unconscious and unable to provide facts concerning his history.

Active "immunization" or "desensitization" by a series of injections of an extract of the insect incriminated or that of mixed insects is commonly employed to provide protection. Whether this extract is best prepared from the venom sac or the whole insect remains a controversial point. In order to utilize the extract of a single insect, however, it is necessary to identify it positively as the cause of the reaction. This presents difficulty, as has already been pointed out.

Long term desensitization with a polyvalent whole body extract derived from bees, wasps, hornets or yellow jackets should be done in persons experiencing systemic reactions. Even though there is evidence of allergy only to one insect, there is a strong likelihood of sensitivity to others due to the common antigens. The various stinging insects used in the polyvalent extract, the dosage and concentration at which desensitization should be started all must be determined by the history of the individual patient correlated with the results of skin tests to various extracts.

Supervision of Desensitization Procedures Important

Desensitization procedures are extremely important and valuable but they must be supervised by a physician who is qualified and experienced in their use. The treatments usually are given at intervals of four to seven days in a graduated dosage schedule. It may be possible for some patients to reach a dosage of 0.2 to 0.3 mm. of a 1:10 dilution while others may tolerate lesser amounts.

Reactions to these extracts occur. If a local reaction larger than a silver dollar is encountered twice with the same dosage (having dropped back and approached that dosage for a second time) then future doses must be regulated to avoid these reactions at injection sites. It is of course important to avoid a systemic reaction from overdosage or from accidental injection into the blood stream. Should such a reaction occur, either immediately or within the 20-minute observation period, a tourniquet is applied above the site of injection and epinephrine hydrochloride 1:1000 dilution is injected in divided doses (0.2 to 0.3 cc.) and repeated

as necessary until the reaction has subsided. Since tourniquets cannot be applied to the buttock area, it is important that injections of this type be given in an extremity.

At the start of this type of treatment, all patients are asked to carry with them at all times a sublingual tablet of Isuprel and an antihistamine so that, if they are stung before maintenance dosage is reached or if they have a reaction to desensitization procedures after leaving the physician's office, these drugs may be taken immediately and the patient must return to the office promptly.

All patients are given their maintenance dose approximately every two weeks in the insect season and every three weeks in the winter for a period of three years and, at the present time, this is being continued for an indefinite period since the ideal length of time has not yet been determined.

The Insect Allergy Committee has evaluated the efficacy of desensitization and, on the basis of its studies, the value cannot be questioned. Last year, 723 persons were restung after desensitization. Six hundred forty-four experienced milder reactions than previously, 48 experienced no change in reaction and 31 suffered more severely. By comparison, of 726 persons restung without desensitization, 393 suffered more severely, 219 noted no change and 114 had milder symptoms than before. This represents a 90 per cent improvement in treated patients and only 15 per cent improvement in those not treated[23].

Prevention of Insect Stings

Unfortunately, there are no repellents available against wasps, hornets, bees and yellow jackets; prevention, therefore, must be directed toward protection against attacks or eradication of nests.

Simple precautionary measures can and should be instituted by the allergic patient; these consist, in part, of adequate screens on windows and doors, avoidance of picnic areas, meticulous cleanliness about garbage containers, avoidance of orchards when trees are in blossom or when fruit is fermenting, and reassignment of hedge clipping duties. In other words, these patients must avoid any site where stinging insects congregate or any situation in which they are known to be particularly aggressive.

More personal recommendations: Clothing should be of plain and light colors, rather than bright colors and of rough finish fabrics; loose fitting clothes which may entrap insects should not be worn; shoes should always be worn out doors; perfumes, scented hair sprays, tonics and lotions should be recognized as definite attractors.

Careful inspection of the house and its environs should be made at regular intervals, starting with the first warm spring weather and continuing through the first fall frost. Nests are more easily removed when they are small, with few insects comprising the colony. The allergic patient would be well advised to call professional exterminators rather than initiate do-it-yourself procedures which might lead to multiple stings.

The United States Department of Agriculture has prepared many useful leaflets and booklets concerning the identification of these common pests, their preferred haunts, peaks of activity and the correct methods of elimination.

A list of references may be obtained by writing to The Journal.

Side Effects—True or False?

THE (FDA) adverse reaction program is off to a fair start and should get better, but concentration on side effects has put too much information into the hands of the laity and the uninformed, who tend to misinterpret. As a consequence, more side effects are being reported now that aren't really side effects, but rather the imaginations of those who got their hands on medical advertising or package inserts.

It is the duty of the manufacturers to provide all the information to the physician about the drugs they make All side effects should be clearly spelled out for him, but they should not be emphasized over and above the therapeutic activity—Robert W. Ballard, M. D., in Food Drug Cosmetic Law Journal.

The Detection of Ocular Signs of Systemic Disease*

Samuel D. McPherson, Jr., M. D.

MANY physicians feel that the detection of eye signs of systemic disorders should be left to the specialist. This is not true.

The equipment and techniques required to determine most conditions are no more than what are present in our offices and which we used in medical school. Furthermore, recognition of ocular changes will frequently enable the practitioner to proceed directly to definitive physical and laboratory examinations and quick establishment of the correct diagnosis.

It is the purpose of this paper to review this equipment and these techniques and to show how they may be useful in the daily practice of medicine.

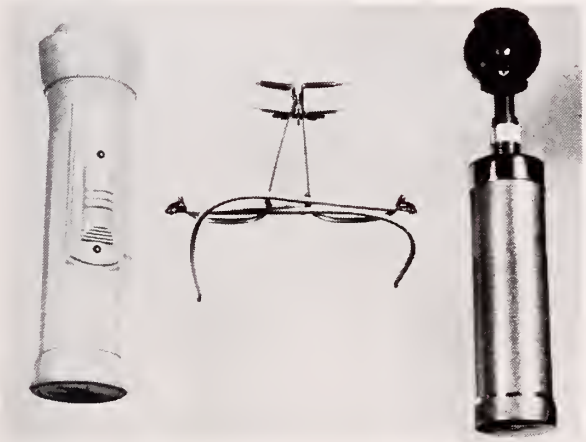

Figure 1. Necessary equipment for diagnostic eye examination.

Equipment

There are three basic items of equipment necessary for these types of examinations (Figure 1). The first is a good hand light. This may be a simple flashlight, a penlight or the type of transilluminator used by most ophthalmologists. The second is some type of binocular magnifying device. The Beebe loupe is the most popular and is not expensive. This is not only useful in examining details of lid, corneal, conjunctival and iris lesions, but also is helpful in the removal of foreign bodies. The third necessary piece of equipment is a hand ophthalmoscope. The same ones we used in medical school are adequate, provided that the lens systems are occasionally cleansed, the filaments focused and new batteries periodically installed.

The Author

- **Samuel D. McPherson, Jr., M. D., McPherson Hospital, Durham, North Carolina; and Clinical Professor of Ophthalmology and Acting Chief of the Division of Ophthalmology, University of North Carolina School of Medicine, Chapel Hill.**

Examinations

External.—Simple observation of the patient's orbits, lids and eyes will frequently show changes which are indicative of systemic disorders. Do the eyes seem to protrude? Are the upper lids retracted above the limbus as in thyroid disease? Is there unilateral or bilateral ptosis suggestive of myasthenia gravis? Ask the patient to follow the hand light as it is moved through six directions of gaze. Is there any limitation of rotation to suggest a third or sixth nerve palsy? Is there lid lag when the patient looks down or weakness of convergence again suggestive of hyperthyroidism? With the loupe on, the physician should then examine the conjunctiva and cornea with the hand light. Does the conjunctiva appear normally moist or is it dry, as in pemphigus? Is the cornea crystal clear or is it cloudy, as in healed syphilitic interstitial keratitis or from calcium deposits in sarcoid? Are there nodules on the iris suggestive of sarcoid or tuberculosis? Are the pupils of similar size and do they react normally to light or is there some discrepancy in the size of the two, suggestive of a brain lesion?

Intraocular pressure can be estimated by palpation of the patient's eye between the forefingers of each of the examiner's hands. This is best done by facing the patient and compressing each eye through the upper lid. After palpating each eye the examiner can then palpate his own to have the same standard for comparison. Although increased intraocular pressure seldom is a sign of systemic disease, it is the most common finding in glaucoma, a blinding disease affecting

*Presented before the second general scientific session of the 98th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 27, 1965.

2 per cent of our population after age 40 and whose early detection is of importance to the patient.

TABLE 1

Age	*Mydriatic**
Less than 40	cyclomydril or 1% mydriacyl
Past 40	10% neosynephrine

Always instill 2 drops of 2% pilocarpine after examination.

---

*Generic and trade names of drugs:
Cyclopentolate hydrochloride and phenylephrine-cyclomydril
Tropicamide-mydriacyl
Phenylephrine-neosynephrine

Ophthalmoscopic.—Satisfactory ophthalmoscopic examinations are dependent upon two things: (1) a bright light and (2) a dilated pupil. A bright light is best assured by a frequent change of batteries. The drugs which we prefer for dilatation of the pupil are shown in Table 1. For patients under 40 years of age we prefer mydricyl or cyclomydril and in persons over 40 years of age, 10 per cent neosynephrine. Drops should be instilled two times at five minute intervals. When the pupils are 5mm. in size the fundi can be satisfactorily seen. With the ophthalmoscope set on a plus 8 lens, the cornea and lens can be well seen and corneal scars or lens opacities noted. As the dial is rotated and the lens power reduced to 0 or minus 2-3, one is focusing through vitreous, and opacities and hemorrhages may be seen. When the posterior pole comes into focus, one should first examine the disk, noting three characteristics: color, cupping and outline. Changes in any of these may be indicative of papilledema or optic atrophy. Remember that the general color of the disk and entire fundus usually parallels the amount of pigment in the patient's skin, pigmented persons having dusky fundi and blonde persons pale fundi. Next the vessels should be examined. Is the artery to vein size 2:3 or are the arteries and arterioles attenuated to produce a 1:2 ratio, as in early hypertension? Are there yellow plaques along the vessels or shiny cholesterol emboli, as in arteriosclerosis? The central and peripheral retina should be thoroughly and systematically inspected and this is not difficult or time-consuming with a dilated pupil. Are there normal highlights from the retina? Are there hemorrhages present? In diabetes, hemorrhages tend to be small, round and deep or very large and prerentinal. Hemorrhages which are moderate sized, superficial and flame-shaped are more common in vascular diseases. Are there exudates present? In many normal fundi small round orange dots may be seen. These are colloid excrescences of Bruch's membrane in the choroid, known as drusen bodies and are frequently confused with exudates. Exudates occur in two varieties and are invariably whiter than drusen. The first type is a small, hard, white exudate usually seen in diabetes. The second is the large, fluffy "cotton-wood" spot seen in vascular and collagen diseases. Other types of fundus changes are not uncommon and the varieties which may occur are so great that one should not hesitate to refer to an atlas to identify these uncommon findings. At the end of the examination a drop of 2 per cent pilocarpine should be instilled to reduce the pupils to normal size.

Visual Fields.—Gross visual field defects are among the easiest ocular changes to be elicited. No equipment is necessary. The examiner seats himself facing the patient and with his face 18 inches from the patient's. The examiner's left hand covers the patient's right eye and the forefinger of the examiner's right hand is brought in from the periphery until the patient first sees it. If the examiner has a normal visual field, both he and the patient should first see the moving finger at the same time in all quadrants. It is important that the patient gaze steadily into the examiner's right eye with his left one.

The process is reversed for the right eye, the examiner's right hand covering the patient's left eye and the examiner's left hand serving as the target. With this type of examination most gross defects such as hemianopsia may be detected.

Summary and Conclusions

The equipment and techniques for simplified diagnostic eye examinations are presented. These are inexpensive and examinations are not time-consuming. Information derived from such examinations can be useful to the practitioner in arriving at exact diagnoses of systemic disorders.

99TH ANNUAL MEETING

of the

West Virginia State Medical Association

The Greenbrier

AUGUST 25-27, 1966

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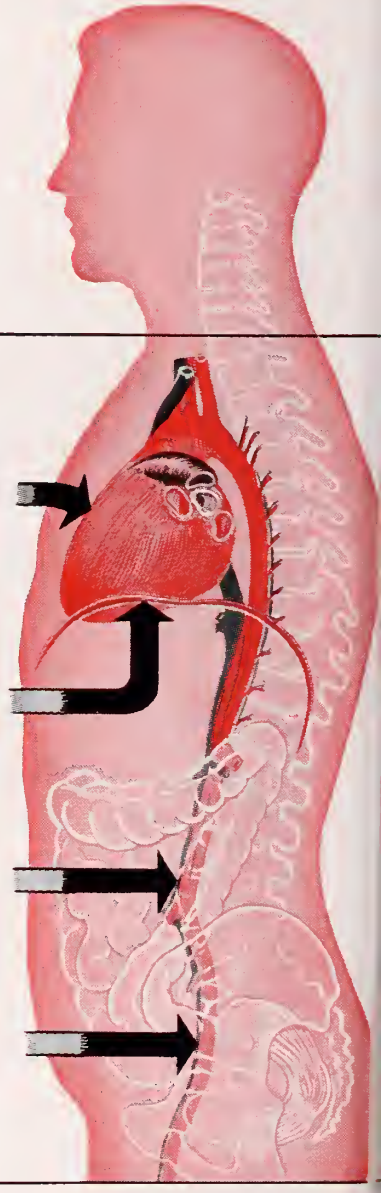

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SEARLE

Research in the Service of Medicine

The President's Page

Guest Author, Mrs. Wilson P. Smith, President
Woman's Auxiliary to the West Virginia
State Medical Association

DOCTOR, DOES YOUR WIFE BELONG?

And if she does, have you wondered if it is worthwhile? To answer these questions may I quote just two of the objectives from the By-Laws of the Auxiliary. These two, I believe, will answer the questions.

First, to assist the West Virginia State Medical Association in its program for the advancement of medicine and public health. Public health may be defined as bridging the gap between scientific advancement and public consumption. The lag here is not only educational but cultural. The doctor's wife, schooled and trained through the Medical Auxiliary, provides an extension of organized medicine. We cannot do the job of carrying out the programs of the State Medical Association if we are lacking in numbers.

The second objective is to cultivate friendly relations and promote mutual understanding among physicians' families. How can we get to know the doctor's wife if she is not one of us. If she is an Auxiliary member and comes to our meetings, I am sure she will find it richly rewarding by the friendship she can bring and find there.

Membership, which is so vital to our organization, yet is so resistant and elusive. People are hard to awaken and cooperation cannot be forced. Each year we work so hard to obtain new members and to hold the old. It is always a problem. Yet it should not be, as the Auxiliary has so much to offer.

We are an unique organization with unique qualifications for membership. Having married a doctor we have an obligation to your chosen profession. It is hard for those of us who have been active members for years to understand the reasons why every wife is not a member. Membership in the Auxiliary connotes loyalty to the Medical Profession and its goals—and a stamp of approval also. We declare to all outsiders that we are proud to be associated with our husbands' professional group and we are willing and anxious to serve our communities as members of this group.

Doctor, we need your interest in the Auxiliary and we need your wife as a member. We need to be a complete unit; the membership of all doctors' wives in the state. We need to have every county an active part of the state organization.

We have important ideas and information to share with your wife and a person-to-person relationship is so far superior to mere printed pages. We need an exchange of ideas and your wife's thoughts as a part of our business.

Perhaps the solution would be the 100 per cent membership plan as proposed by our National Auxiliary. This would mean that you would pay your wife's dues at the time you pay your West Virginia and AMA dues. Maybe if she automatically belonged she would come to our meetings—then she would see just how much the Auxiliary has to offer.

Doctor, if your wife does not belong to the local county Medical Auxiliary, would you ask her why and give us the reasons?

Maida S. Smith

THE WEST VIRGINA MEDICAL JOURNAL

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The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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EDITORIALS

LOOKING AHEAD

For the past year physicians have been deluged through all news media with fact and fiction concerning Medicare. A few of us have been seeking advance information on the machinery and process of the new era but most of us have deferred interest until the day of action—July 1, 1966. All of us have been urged to participate in and cooperate with the new deal in every way.

Medicare is a situation in which each physician must define and prescribe his own course of action. Individual reaction will depend on many facets such as area and type of practice, personality, political and medical philosophy. Medicare at this time, in this state, pertains only to the Social Security group but in due course Section XIX will be activated to care for MAA, needy children, the blind and the totally and permanently disabled. The ramifications of Medicare, such as hospital utilization, will be extended by staff and administration to all hospital admissions and a hospital group such as medical audit committee can hold a club over any physician whether he be pediatrist or geriatrist. Medicare brings to the physician the most profound change in the concept of medical practice of this century.

Physicians will continue to care for the sick regardless of age or income and will provide for the sick the best medical service available in any land. It is hoped that increasing contact of medicine with administration and government may be accomplished with mutual satisfaction. Rules, regulations and inflexibility do not exist within our profession but are the substance of bureaucracy. The medical profession will tend to accommodate itself to medical needs but not to arbitrary, rigid officialism.

The many conferences now being held on Medicare show a maximal amount of medical interest and desire for information. The coining of such phrases as prevalent, usual and customary care, should not lull us into the delusion of complete cooperation, but should serve only to increase our vigilance in order to preserve those medical freedoms that remain with us. This is the honeymoon. The squabbles and altercations will come later. When that time arrives, if history repeats itself, arbitration will give way to attrition and a few more details of free medical practice will be whittled away. We can only trust that our leaders who preach cooperation now will be aware of future faults and will be able to arbritrate differences without compromise.

There is an old saying that cooperation is a two-way street but it depends on who has the power and who is cooperating. The designation of Nationwide as intermediary for Part B of Medicare represents the usual governmental unilateral view of cooperation. West Virginia has been well served by the Blue Shield plans. The

number of Blue Shield clients in West Virginia far exceeds the business of Nationwide. One wonders what influences could offset the years of service, profound satisfaction and agreement that exists between Blue Shield and West Virginia Medicine. It is an unsavory beginning for the great experiment.

Physicians must determine in consultation with their patients whether to accept or reject insurance assignment. At a recent national conference of ASIM, it was the unanimous decision to refuse to accept assignment. Again, decision will depend on the past relationship of physician and patient.

So as we plunge into the 1966 brand of Medicare we must try to retain at any sacrifice a satisfactory physician-patient accord. Medicare is in its infancy, so don't be distressed by the many rules and regulations. Like Social Security, its future is at the whim of any vote getting Congressman and changes may be expected before you learn the details of the original package.

"CAST YOUR BREAD . . ."

"Cast your bread upon the waters, and it shall be returned many fold."

This biblical axiom was allegedly demonstrated when the Nationwide Mutual Insurance Company of Columbus, Ohio, was designated as intermediary for the supplementary medical care program of Public Law 89-97 (Medicare) in all but five counties in Ohio and all of West Virginia. The announcement was received with definite consternation in medical circles of both states. Any critic of this selection by the Social Security Administration must admit that the Nationwide complex has the size and capability of handling the program, if it is their desire. It is true that Best's Insurance Guide gives Nationwide an A plus 5A rating.

In the light of our (West Virginia) request that Blue Shield be appointed as intermediary, and the refusal to date of any reconsideration by Mr. Arthur Hess, Social Security Administrator, of the request by the Chairman of the Council for such action, it might be of interest to look into the background for clues as to why the appointment was made.

This writer has before him the transcript of testimony given before the Ways and Means Committee of the House of Representatives in January 1964. A Mr. Rennie, vice president of Nationwide, prefaced his statement with these words: "Mr. Lincoln regrets that he cannot present this testimony in person . . . and has asked me represent him."

He stressed several points as follows: (1) "The company supports the social insurance principle to meet the health needs of older people; (2) We see the possibility of true partnership in the King-Anderson bill and feel that approach must be made through a social insurance system; (3) We see the whole area of major medical coverage as building on the basic provisions of hospital and nursing home coverage; and (4) We see the possibility of providing medical and dental services and other facilities."

If one uses the definition of "social insurance" in the connotation adopted by organized medicine, then Mr. Lincoln and his cohorts must be marked as liberals and their recommendations are but well-planned steps toward the complete socialization of our profession.

Despite our objections, it is evident that when chaos and confusion arrive next July, the physicians of West Virginia will do business, either directly or by assignment of claims for payment, with the liberal-minded complex from Ohio.

From the circumstances surrounding this entire matter, one might well allege that casting one's bread on the water sometimes results in the return of a well-iced cake.

Despite the alleged possibility that bakery products may have been exchanged, the majority of our profession will strive for an equitable association during the year in which this intermediary contract is in force, looking always for means for improving the status of federally sponsored medical practice.

THE DETECTION OF OCULAR SIGNS OF SYSTEMIC DISEASE

In a scientific paper in this issue of *The Journal* entitled, "The Detection of Ocular Signs of Systemic Disease," Dr. Samuel D. McPherson, Jr., one of the guest speakers at the 98th Annual Meeting at The Greenbrier last August, has given us the techniques and describes the equipment used for an excellent, easily readable, and simplified diagnostic eye examination.

The author takes the reader with him as he performs the various phases of this examination and voices the many pertinent and important questions that are presented with the various parts examined. The deftly put differential diagnostic points are gems in pinpointing the possible existence of systemic disease. The simplicity of the instruments used and the path followed makes this must reading for all physicians.

It properly points out that "to know the normal well makes it much simpler to recognize the abnormal." Doctor McPherson's paper, like a well routed road map, leads the reader through

the external and internal structures of the eye and then over the face of the fundus to point out important diagnostic criteria which are so valuable in leading to the evidence of other diseases. Some of the findings suggest the referral to an ophthalmologist such as questionable visual fields and increased intraocular pressure or unusual fundus findings and would make the American Association of Ophthalmology's slogan truly appropriate when it says that, "An ophthalmologist's examination may not only be sight saving—it may be life saving." The detailed guides to the various mydriatics and equipment are noted.

It may truly be said that Doctor McPherson's scientific paper in this issue of *The Journal* is a valuable addition to our diagnostic literature.

WAR ON QUACKS

"Physicians, as conservators of the public health, are bound to bear emphatic testimony against quackery in all its forms."

Is this a quote from proceedings of the American Medical Association's Clinical Convention in Philadelphia in December? The meeting was in Philadelphia, but the year was 1847.

So you see, from its very inception 118 years ago, the American Medical Association has been battling quackery and it is dedicated to a continuation of this warfare against wasting the nation's health and its health care dollar . . . of fighting fraud at the bedside of ill and desperate people.

For, as long as there are human beings, there will be human nature . . . and quacks—pretenders to ability they don't possess—to take advantage of the fact.

The health quack is not so easy to spot these days. The stovepipe hat and the pitchman's hawking have gone. In their place are their space-age counterparts, the suave, apparently-sophisticated super salesmen with the Madison Avenue manners.

These merchants of menace, more insidious and unscrupulous than ever, have many new products, worthless diet fads, worthless food supplements, worthless cosmetic devices and treatments, worthless "cures" for everything—even into the area of brain-damaged children and other mental illness.

They bilk the undiscerning—the uninformed, the desperate, the unsuspecting of all ages—of millions of dollars a year. The estimates of the costs of medical quackery are at best calculated guesses, but they have gone as high as a billion dollars a year. And one authority in the field of quack-fighting has stated that "medical quackery each year costs more lives than all crimes in the United States."

It is this cost of life—and health—that has placed America's physicians in the front lines of the war on quacks. It is the insidious side effect of quackery with which medicine concerns itself —the delay in proper medical care that may cost life itself.

It is for this reason, too, that the medical profession is dedicated to education of the people about cultism—chiropractic and the other health sects that turn their backs on scientific medicine.

The House of Delegates of the American Medical Association said in 1933:

> "Either the theories and practices of scientific medicine are right and those of the cultists are wrong, or the theories and practices of the cultists are right and those of scientific medicine are wrong."

And in 1961, it said:

> "There can never be a majority party and a minority party in any science . . ."

After the quack or the cultist has extracted his pound of flesh—after the damage is done and after the sick may have become the dying because of the delay in proper care—scientific medicine usually is called upon to pick up the pieces.

Medicine has tried and will continue to try to do that job, too, but how much easier the job would have been—how many lives would have been saved—if . . .

'TIS AN ILL WIND

'Tis an all wind that blows no good for some of us but not so for the Livelys, even though the ill wind may be disguised as a fractured arm.

In the middle of the night of February 23, little Bill Lively, age 6, suffering with a broken arm, restless and wakeful, became fearful about a noxious odor in the night air. Prompt investigation by little Bill found the home full of smoke and flame. Cinda and Bill, in deeper slumber than usual because of the distress and anxiety of the day, were finally prodded into wakefulness by their first born. Prompt arrival of the firemen prevented serious material damage and the courage and quick thinking of little Bill may have saved the household from tragedy.

To the Livelys, we offer our sincere sympathy for property loss and temporary discomfort and we are deeply grateful for the "ill wind" that prevented a family catastrophe.

To little Bill our best wishes for a speedy convalesence and a distinguished service award for gallantry under fire.—The Publication Committee.

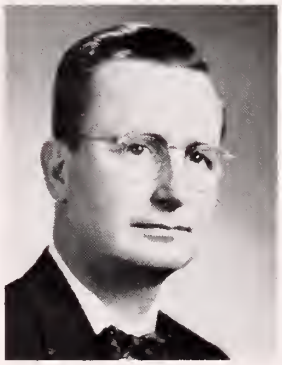
GENERAL NEWS

Drs. Priestley and Wise To Speak At 99th Annual Meeting

Two prominent physicians have accepted invitations to appear as guest speakers at the 99th Annual Meeting of the West Virginia State Medical Association which will be held at The Greenbrier in White Sulphur Springs, August 25-27.

Dr. Carl B. Hall of Charleston, Chairman of the Program Committee, said that Dr. James T. Priestley of

James T. Priestley, M. D.



Robert I. Wise, M. D.

Rochester, Minnesota, and Dr. Robert I. Wise of Philadelphia, have accepted invitations to present papers during the three-day meeting. There will be three speakers at the general sessions on Thursday and Friday and the program on Saturday morning will be presented by members of the faculty of the WVU School of Medicine.

Doctor Priestley, who is Head of a Section of Surgery at The Mayo Clinic and Professor of Surgery at the Mayo Graduate School of Medicine, University of Minnesota, will appear as a speaker at the first general scientific session on Thursday morning, August 25.

Doctor Priestley, a native of Des Moines, Iowa, was graduated from the University of Pennsylvania and received his M. D. degree in 1926 from the University of Pennsylvania School of Medicine. He interned at the University of Pennsylvania Hospital in Philadelphia, 1926-28.

He received an M. S. degree in experimental surgery in 1931 and a Ph. D. in surgery in 1932 from the University of Minnesota. He served in the Medical Corps of the United States Army during World War II with the rank of Lieutenant Colonel.

Doctor Priestley served as President of the American College of Surgeons, 1964-65, and he is a member of a number of other scientific organizations. He was certified by the American Board of Surgery in 1940.

Robert I. Wise, M. D.

Dr. Robert I. Wise, Magee Professor of Medicine and Head of the Department at Jefferson Medical College, will appear as a speaker at the second general scientific session on Friday morning, August 26.

He was born in Barstow, Texas, and was graduated from the University of Texas. He received a Ph. D. degree in 1942 from the University of Illinois and an M. D. degree in 1950 from the University of Texas School of Medicine.

He interned at the U. S. Public Health Service Hospital in New Orleans, 1950-51, and served a residency at the University of Minnesota, 1951-53. He served for two years as Assistant Professor of Medicine at the University of Minnesota School of Medicine.

Doctor Wise, who also serves as Physician-in-Chief at Jefferson Medical College Hospital, was certified by the American Board of Internal Medicine in 1957.

Doctor Wise is a Fellow of the American College of Physicians and is a member of the Editorial Board of *Annals of Internal Medicine*. He also serves as a member of the Advisory board of *The Medical Letter*.

Scientific Program Nearly Completed

Doctor Hall announced that arrangements have nearly been completed for the general scientific program which will be presented during the three-day meeting. The other members of the Program Committee are Drs. William E. Gilmore of Parkersburg, W. Gene Klingberg of Morgantown and Halvard Wanger of Shepherdstown.

It was announced previously that Dr. Charles L. Hudson of Cleveland, President Elect of the American Medical Association, had accepted an invitation to appear as speaker at the first session of the Association's House of Delegates on Wednesday afternoon, August 24. Doctor Hudson will be installed as President of the AMA at the Annual Convention in June.

Another honor guest will be Gov. Hulett C. Smith, who has accepted an invitation to appear as a guest speaker prior to the opening of the general session on Thursday morning, August 25.

Doctor Hall said that members of the Auxiliary and other guests attending the meeting at The Greenbrier are cordially invited to listen to the addresses by Governor Smith and Doctor Hudson.

Additional information concerning the program will appear in future issues of *The Journal*. The complete program will be published in the Convention Number in August.

Diversified Program Planned For Pediatric Meeting

Closed circuit television clinical presentations from Montreal Children's Hospital will be among the features of the annual spring session of the American Academy of Pediatrics. The meeting will be held in Montreal, Canada, April 25-27.

Other features of the program include a diversified scientific program and more than 90 scientific and technical exhibits.

The television presentations will cover such subjects as the management of the sick newborn infant, cerebral palsy, learning disorders and growth problems. Papers will be presented on problems of carbohydrate metabolism, management of cardiac failure in children with acyanotic congenital heart disease, pulmonary hypertension, pediatric surgery, genetics, congenital disorders, and other subjects.

More than 3,000 pediatricians, their families and guests are expected to attend the sessions.

Additional information may be obtained by writing to the American Academy of Pediatrics, 1801 Hinman Avenue, Evanston, Illinois.

On-the-Job Training Program Planned in W. Va. Hospitals

The U. S. Department of Labor and the West Virginia Hospital Association have entered into an agreement regarding the on-the-job training of nonprofessional personnel.

The federal agency is making a one-year grant of $75,000 in training funds and $32,700 in administrative funds. An additional $50,000 in training funds would be available within a year if the project shows signs of success.

Participating institutions must give assurances that trainees will be employed by them. Other conditions are as follows:

Trainees will be selected by the institutions, but they must be cleared through the Department of Employment Security to assure that they are unemployed or under-employed; institutions pay wages while the trainees are in training; and the Association will provide leadership in setting up the programs, pay the cost of instructors if they are needed or a pro-rata portion of the salaries of persons already employed at the institutions, and pay the cost of lesson outlines, training aids and other materials.

Dr. Sadler Heads Pathology Group

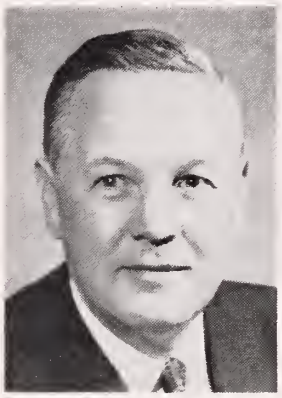
Dr. J. Evan Sadler of Huntington was elected President of the West Virginia Association of Pathologists during a recent meeting of the Board of Directors in Huntington.

Dr. Peter P. Ladewig of Charleston was named President Elect and Dr. Dennis S. O'Connor of Huntington was elected Secretary-Treasurer. Drs. Charles R. Chamberlain of Morgantown and Grover B. Swoyer of Charleston were elected members of the Board.

Gov. Hulett C. Smith Honor Guest At 99th Annual Meeting

Gov. Hulett C. Smith will be among the honor guests at the 99th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 25-27.

Dr. Carl B. Hall of Charleston, Chairman of the Program Committee, announced that the State's Chief Executive had accepted an invitation to appear as a guest speaker at the first general session on Thursday morning, August 25. His address will follow opening remarks by Doctor Hall and Dr. Seigle W. Parks of Charleston, President of the West Virginia State Medical Association. His subject will be announced at a later date.



Gov. Hulett C. Smith

Governor Smith was born in Beckley, son of the late Congressman Joe L. Smith and Christine Carlson Smith. He was educated in the public schools of Raleigh County, attended Beckley College and received a B.S. degree in economics from the Wharton School of Finance and Administration of the University of Pennsylvania.

During World War II, he served as a Lieutenant in the United States Navy. He returned to Beckley in 1946 where he was active in the business community. He served as a director and treasurer of the Beckley and Oak Hill hospitals from 1953 to 1965.

Governor Smith served as Chairman of the State Democratic Executive Committee from 1956 to 1961, and was appointed first Commissioner of the West Virginia Department of Commerce in 1963.

He was elected the 27th Governor of West Virginia on November 3, 1964, and was inaugurated on January 18, 1965.

He is married to the former Mary Alice Tieche of Beckley, and they have five children.

AMA Makes Guide Available

The American Medical Association is making available the eighth in a series of "Guides to the Evaluation of Permanent Impairment."

The new guide is entitled "Guides to the Evaluation of Permanent Impairment—The Respiratory System." It was developed by AMA's Committee on Rating of Mental and Physical Impairment.

A limited number of copies may be obtained upon request and without charge by writing to the Committee on Rating of Mental and Physical Impairment, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Dr. Charles L. Hudson Speaks At Officers Workshop

Dr. Charles L. Hudson of Cleveland, President Elect of the American Medical Association, urged greater physician participation in the affairs of organized medicine in an address at the County Medical Society Officers Workshop which was held in Charleston on March 13.

Doctor Hudson's keynote address was entitled, "Closer Cooperation Among County and State Medical Societies and the American Medical Association." He stressed that the individual physician is the very foundation of the AMA.

AMA Leads In Learning

"It is the purpose of the AMA to lead you and me in learning," he said. "The AMA speaks for American medicine and it leads the progress of American medicine. AMA leadership, however, is vested by local and state medical societies. These societies, in turn, derive their strength from their individual members."

The AMA, he said, is a large organization, and "unfortunately, there are some who equate 'bigness' with 'monopoly' or 'concentration of power' or other equally vague and indefinite phrases."

Registration Totals 53

Fifty-three physicians and others registered for the Workshop, the first conference of its kind to be arranged by the West Virginia State Medical Association. The Workshop was preceded on Saturday, March 12, by an "Institute on Utilization Review," which was co-sponsored by the State Medical Association and the West Virginia Hospital Association.

Seventeen of the State Medical Association's 28 component societies were represented at the Workshop. Kanawha Medical Society led the list of registrations with 13 members present.

Six members of the Raleigh County Medical Society attended, and Cabell, Central West Virginia, Eastern Panhandle and Mercer Medical Societies each had three members present.

Committee Chairmen Speak

In addition to Doctor Hudson, other morning speakers on the Workshop program were Dr. Seigle W. Parks of Charleston, President of the State Medical Association, and the following chairmen of standing committees of the Association:

Drs. Joseph L. Curry of Wheeling, Public Service; Frank J. Holroyd of Princeton, Legislative; William B. Rossman of Charleston, Mental Health; Pat A. Tuckwiller of Charleston, Medical Education and Hospitals; George R. Callender, Jr., of Charleston, Medical Economics; C. A. Hoffman of Huntington, Insurance; and Harry S. Weeks of Wheeling, Joint Conference Committee.

Each chairman briefed workshop participants on the work of his committee and brought them up to date on its activities.

Dr. Charles L. Hudson (top), President Elect of AMA, delivers keynote address at Workshop. In registration line for Utilization Review Institute (middle photo) are Dr. W. Hampton St. Clair, Jr., of Bluefield, Mr. J. E. Peery of Welch; and Dr. E. Lyle Gage of Bluefield. In bottom photo, Dr. John J. Mahood of Bluefield registers for Workshop.

In top photo, Dr. Stephen Mamick of Welch (left) discusses Workshop program with Dr. Lawrance S. Miller of Morgantown. Dr. Aarom Boonsue of Mullens (left in center photo) chats with Dr. Frank J. Gavlas of Martinsburg. In bottom picture, Doctor Hudson (center) is shown with Dr. Richard E. Flood of Weirton and Dr. Seigle W. Parks of Charleston.

Panel Discussion

The afternoon session was devoted to a panel discussion on "Current Challenges to Medicine," which was moderated by Dr. Richard E. Flood of Weirton, President Elect of the Association.

Panelists included: Hon. L. L. Vincent, Commissioner of the West Virginia Department of Welfare; Dr. B. B. Richmond, Medical Director of the Health Insurance Benefits Unit of the State Health Department; Dr. Albert C. Esposito of Huntington, Chairman of the Council of the Association; and Dr. Clark K. Sleeth, Dean of the West Virginia University School of Medicine.

AMA Represents All Physicians

Doctor Hudson stressed the necessity of strengthening organized medicine at all levels. He said:

"Though the AMA does not envision itself as being all things to all people, it will continue to strive to be representative of all the physician population—the practitioners, the academicians, the medical administrators, the young, the old, the 'left' and the 'right' . . .

"At this point in time, careful consideration needs to be given to strengthening our federation. If the Association is to be effective nationally, it must first be effective locally for local societies are the critical foundation of the federation."

Professional Obligations

Doctor Hudson went on to say that the physician's first professional obligation is to himself and his patients, but "his second major obligation is an active participation in his local medical society. . . ."

It is at the local society level, he said, "that the all-important grassroot opinions of individual physicians originate."

Communication is a basic ingredient of cooperation, Doctor Hudson noted. "Members will not become interested in their societies if they are not made aware of the problems, the projects, and the working mechanisms of the societies."

Staggers Committee

He noted that Congressman Harley O. Staggers of Keyser is now Chairman of the important House Interstate and Foreign Commerce Committee, which handles the bulk of national medical and health legislation.

Doctor Hudson said this situation gives West Virginia physicians an opportunity to help convey medicine's viewpoint on health legislation to Washington.

"I strongly urge you to work with your officers and staff on a soon-to-be-developed program which will bring medicine's viewpoint to the attention of Congressman Staggers and all your congressmen."

Utilization Review

The Utilization Review Institute on Saturday attracted about 185 hospital administrators, chiefs, physicians and others concerned with hospital administration.

Speakers included: Doctor Richmond; Dr. Vergil M. Slee, Director of the Commission on Professional and Hospital Activities in Ann Arbor, Michigan; Mr. James Ensign, Vice President of Professional Relations, Blue Cross Association, Chicago; and Mr. Joel Edelman, Assistant Director, Michael Reese Hospital, Chicago.

Dr. and Mrs. Daniel E. Hendricks and Dr. John H. Kilmer (right), all of Martinsburg, enjoy luncheon between Workshop sessions in left photo. Right photo shows Committee chairmen who gave reports. 1st row: Dr. Pat A. Tuckwiller of Charleston, Medical Education and Hospitals; Dr. Joseph L. Curry of Wheeling, Public Service; and Dr. George R. Callender, Jr., of Charleston, Medical Economics. 2nd row: Dr. William B. Rossman of Charleston, Mental Health; Dr. Frank J. Holroyd of Princeton, Legislative; and Dr. Harry S. Weeks of Wheeling, Joint Conference Committee.

Left photo shows three panelists at afternoon Workshop session. Left to right: Mr. L. L. Vincent, State Welfare Commissioner; Dr. Richard E. Flood of Weirton; and Dr. Albert C. Esposito of Huntington. Not shown are Drs. B. B. Richmond of Beckley and Clark K. Sleeth of Morgantown. Right photo, left to right: Mr. Charles L. Showalter of Charleston, President of the West Virginia Hospital Association; Dr. Seigle W. Parks of Charleston, President of the West Virginia State Medical Association; Dr. Vergil M. Slee of Ann Arbor, Michigan; and Dr. B. B. Richmond of Beckley.

Among those attending the Institute were (left picture) Drs. T. Kerr Laird of Montgomery, C. H. Engelfried of Charleston and Clint W. Stallard of Montgomery. Three members of the Central West Virginia Medical Society get together in picture at right. Left to right: Drs. J. C. Huffman of Buckhannon, Charles T. Lively of Weston and R. L. Chamberlain of Buckhannon.

Gov. Smith Names 8 Doctors To Health Task Force

Gov. Hulett C. Smith has invited eight doctors of medicine to serve on his 27-member Task Force on Health, which will be headed at least temporarily by State Institutions Commissioner Chauncey H. Browning, Jr.

The group "will explore the obvious shortage of doctors and medical personnel and facilities in our rural areas," Governor Smith explained. "It also will look into the pressing need for new facilities for long-term care, mental health, and public health services in every section of the state."

"Particularly, I want the Task Force on Health to study the relationship between the West Virginia University Medical Center, the State Health Department, and local health bodies, and our public institutions. This is a big job, because these are big problems."

The Governor asked the following doctors to serve:

Seigle W. Parks of Charleston, President of the West Virginia State Medical Association; Frank J. Holroyd of Princeton; Mildred M. Bateman, Director of the State Department of Mental Health; and Robert L. Vosburg of Morgantown, Chairman of the Department of Psychiatry at the West Virginia University School of Medicine.

Ernest W. Chick, Chairman of the Division of Public Health and Preventive Medicine at the School of Medicine; N. H. Dyer, Director of the State Department of Health; James H. Walker of Charleston; and Martha J. Coyner of Harrisville.

The remaining members of the task force were drawn from private industry, higher education, organized labor, state and federal agencies, and health and hospital groups.

Mr. Harry C. Wolfe of Bartow was named Consultant to the group and will act as its Executive Director.

The Governor also appointed Dr. David W. Mullins of Logan, a State Senator, to the Task Force on Surface Mining.

W. Va. Acad. of Oph. & Otol. Meeting at The Greenbrier

Six physicians will present papers at the 19th annual meeting of the West Virginia Academy of Ophthalmology and Otolaryngology which will be held at The Greenbrier in White Sulphur Springs, April 13-16.

Speakers on ophthalmology will be Drs. Jorge Buxton of New York City, William F. Hughes of Chicago and H. Saul Sugar of Detroit. Drs. T. Manford McGee of Detroit, Charles M. Morris of Philadelphia and Philip Sprinkle of Morgantown will lecture on subjects related to otolaryngology.

Registration fee is $35 for nonmembers. This covers the scientific sessions and social events.

Additional information may be obtained by writing to Dr. J. Elliott Blaydes, 107 Federal Street, Bluefield.

Dr. Morris Fishbein Speaks At Jackson's Mill

Dr. Morris Fishbein of Chicago, former Editor of the *Journal of the American Medical Association,* was scheduled as guest speaker at the Stonewall Jackson Memorial Hospital Community Dinner at Jackson's Mill on March 17.

Doctor Fishbein planned to arrive in Weston with a close friend, Dr. Charles A. Haney of Newtonville, Massachusetts. They were to tour the hospital, then proceed to Jackson's Mill for the dinner.

Doctor Fishbein, one of the nation's best known physicians, has been a prolific contributor to professional and lay publications over the years. His last public appearance in West Virginia was at the Potomac-Shenandoah Valley Postgraduate Institute in Martinsburg last October.

Regional Orthopedic Meeting In Morgantown on Apr. 2

Dr. Justus C. Pickett of Morgantown will preside at a regional meeting of the American Academy of Orthopedic Surgeons which will be held at the WVU Medical Center in Morgantown on Saturday, April 2.

Doctor Pickett, who is Chairman of the Division of Orthopedic Surgery at the WVU School of Medicine, is currently serving as Chairman of the Regional Council of the Academy. He said that the meeting will be attended by representatives from Virginia, North Carolina, Tennessee, Kentucky and West Virginia.

Doctor Pickett also announced that Dr. Carroll B. Larson of Iowa City, Iowa, President of the Academy, and Mr. John K. Hart of Chicago, the Executive Secretary, plan to attend the one-day meeting. Attendance at the meeting is restricted to members of the Academy.

Raleigh Society Contributes $1,350 to Scholarship Fund

The Raleigh County Medical Society has made a contribution of $1,350 to the Charles Lively Memorial Scholarship Fund of The West Virginia State Medical Association.

The contribution came as a result of the medical profession's role in "Operation Headstart," which was conducted in Raleigh County last summer. Members of the Society voted to donate their fees for services rendered to a special fund to aid deserving programs.

In addition to the contribution to the Association's Scholarship Fund, the Society allocated $1,350 to the Raleigh County Public Library and $500 to the Parent's League of Beckley.

New Association Members

Dr. Harry C. Bauer, The Wheeling Clinic, Wheeling (Ohio). Doctor Bauer, a native of Moontz, Illinois, was graduated from Southern Illinois University and received his M. D. degree in 1953 from Temple University School of Medicine. He interned at Johnstown Memorial Hospital in Johnstown, Pennsylvania, 1953-54, and served a residency at Baylor University Hospital in Houston, Texas, 1958-62. His specialty is pathology.

* * * *

Dr. Bobby Lee Caldwell, Memorial Hospital, Charleston (Kanawha). Doctor Caldwell, who was born in Catawba County, North Carolina, was graduated from Wake Forest College and received his M. D. degree in 1959 from the Bowman Gray School of Medicine. He interned and served a residency at Charleston Memorial Hospital, 1959-63. He served as a Captain in the Medical Corps of the United States Army, 1963-65. His specialty is pathology.

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Dr. James M. Carter, 1133 Market Street, Parkersburg (Parkersburg Academy). Doctor Carter, who was born in Highland County, Virginia, was graduated from Lynchburg College and received his M. D. degree in 1953 from the University of Virginia School of Medicine. He served an internship at McKeesport, Pennsylvania, 1953-54, and served a residency at the University of Virginia School of Medicine, 1956-59. He served in the United States Navy, 1944-45, and he was previously located in Marquette, Michigan. His specialty is radiology.

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Dr. Hyeum S. Chu, Pilgrim State Hospital, West Brentwood, N. Y. (Central W. Va.). Doctor Chu, who was born in North Korea, received her M. D. degree in 1948 from the Seoul Woman's Medical College in Seoul, Korea. She interned at St. Mary's Hospital in Huntington, 1954-55, and served a residency at St. Mary's and several hospitals in the state of New York. She was a member of the staff of Weston State Hospital from 1961-1965. Her specialty is psychiatry.

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Dr. John W. Kramer, 1120 Locust Avenue, Fairmont (Marion). Doctor Kramer, a native of Marine City, Michigan, was graduated from Yale University and he received his M. D. degree in 1955 from the University of Michigan. He interned at St. Luke's Hospital in Cleveland, Ohio, 1955-56, and served a residency at the University of Maryland Hospital, 1959-63. He served as a Captain in the Medical Corps of the United States Army, 1957-59, and previously was located in Michigan. His specialty is general surgery.

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Dr. Thomas R. Poole, 3414 Staunton Avenue, S. E., Charleston (Kanawha). Doctor Poole, a native of Brushton, was graduated from Marshall University and attended the two-year WVU School of Medicine. He received his M. D. degree in 1961 from the Medical College of Virginia, and he interned and served a residency at Charleston Memorial Hospital, 1960-65. He served in the United States Army, 1953-55. His specialty is obstetrics and gynecology.

Eli Lilly & Co. Announces Welfare Prescription Program

Eli Lilly and Company has announced a program for state welfare agencies which will enable the states to obtain 51 separate Lilly items at reduced cost for welfare patients.

The products include sedatives, hypnotics, antidepressants, diuretic-antihypertensives, analgesics and antibiotics.

Under the agreement, participating states will receive a cash remittance from Lilly from time to time. This will equal 15 per cent of the amount of money the company receives for the Lilly drugs paid for by welfare departments.

Lilly said welfare recipients would be free to obtain drugs from pharmacists of their choice.

AMA-ERF Issues Progress Report On Loan Program

The four-year-old AMA-ERF Loan Guarantee Program grew by 11 per cent last year, a recent report shows.

During 1965, 8,213 medical students, interns and residents received loans with a total principal sum of $9,573,050. This brought the total borrowing for the program since it began in March 1962 to 27,511 loans worth $31,857,138 in principal. Defaults in repayment are running less than one per cent.

Sixty-seven loans totaling $79,700 were extended to residents, interns and medical students studying in West Virginia in 1965, compared with 64 loans with a principal amount of 79,000 during the previous year.

More than 10,000 individual physicians gave to the Loan Program in 1965, and auxiliaries again contributed a significant sum through benefits and special fund-raising projects. Industry support was paced again by a $100,000 gift from Merck Sharp & Dohme, its fourth contribution of that amount.

Last of Nursing Workshops To Be In Charleston

The last in a series of six workshops on "Leadership in Nursing Supervision and Administration" will be held at the Holiday Inn in Charleston, April 18-22.

Supervisory nursing personnel from hospitals in West Virginia, Ohio, Virginia, Tennessee and North Carolina are expected to attend. The series is designed to assist nurses in developing managerial skills.

Two series of three workshops were held in Charleston and Morgantown. The Morgantown series ended March 25.

Federal Aid Allocated For Mental Health Centers

Studies indicating that thousands of disturbed persons who received intensive care in comprehensive mental health centers are rapidly returning to jobs and families have prompted Congress to authorize funds for construction of community mental health centers. The State Department of Health has been assigned to administer the construction program for these centers on the state level.

State Health Director N. H. Dyer, in a recent issue of the "State of the State's Health," said the aim behind the concept of comprehensive community mental health centers is individual treatment of needs as to progress from early diagnosis through a continuity of treatment and back to a productive life in the community without the harmful effects of an isolated institutional hospital residence.

Doctor Dyer pointed out that each community mental health center will have its own characteristics and may not necessarily be under one roof nor even a single sponsorship. He added that a center should offer the following services: inpatient, outpatient, partial hospitalization, community, diagnosis, rehabilitation, precare and aftercare, training, and research and evaluation, although a center may begin with only five essential services—inpatient, outpatient, emergency care, day care and community service.

Doctor Dyer explained that most centers now in operation began with an outpatient guidance clinic and added other services in time. He said that it may take years to achieve a totally comprehensive service.

"The centers will be situated close to the patient's home community so that the patient can receive the sort of treatment he needs when he needs it in surroundings which are familiar to him," Doctor Dyer said. "His family physician may continue to see him and participate in his treatment. In this manner, the patient can more readily resume his normal life when his treatment has been concluded. Some patients need not give up their jobs during treatment for some programs only average from eight days to a month. For the mentally disturbed mother, treatment in her community can mean the difference between the breakup of the family and the maintenance of its continuity since, in many instances, she will be able to continue to assume at least a part of her family responsibilities."

Doctor Dyer noted that in addition to family physicians, the clergymen of the community, the lawyers, the health and welfare agency staffs, the public health nurses, the teachers and the other guardians of mental health can consult with the center's professional staff to aid in serving individual patients, as well as to add to their own knowledge of mental illness and mental health through formal and informal classes and meetings presented by the center's staff.

For the purpose of constructing community mental health centers, West Virginia has been allotted $923,146 for fiscal years 1965 and 1966. The rate of federal participation is a uniform rate of 61 per cent for all projects in the state. The balance of 39 per cent is to be provided by the applicant. At present, the Bureau of Hospitals and Medical Facilities has not received an application from any sponsor for the proposed construction of a comprehensive community mental health center.

In another issue of the "State of the State's Health," Doctor Dyer reported on the nursing component of the Health Insurance Benefits Program which is primarily concerned with the provision of safe quality nursing care that the beneficiaries need and are entitled to. Doctor Dyer said that home health services will be provided through an agency that is certified to render services in the home setting. In order to be certified, the agency must be primarily engaged in providing skilled nursing care. In most instances, the local or regional health department will be the only agency that will meet this requirement.

Doctor Dyer noted that the Bureau of Public Health Nursing is planning for intensive inservice education programs geared to augment and supplement nursing knowledge and skills in caring for the sick at home.

Medical Technologists Announce Meeting Program

The West Virginia Society of Medical Technologists, Inc., has announced the program for its 18th annual meeting which will be held at the Shenandoah Hotel in Martinsburg, April 21-23.

Pathologists from West Virginia, Virginia and Maryland will speak at the scientific sessions.

A mycology workshop is scheduled for Thursday morning, April 21, with a discussion of plasma electrophoresis planned for that afternoon. On Friday morning, there will be a symposium on National Convention Issues before the House of Delegates.

The winner of the Best Student Paper Contest will be selected Friday afternoon. This will be followed by a business meeting of the Society.

Saturday will be devoted to a tour of the Veterans Administration Center in Martinsburg and additional lectures.

The annual banquet will be held on Saturday evening with Rose Matthaei, Executive Secretary of the American Society of Medical Technologists, as the speaker.

Additional information may be obtained by writing to Mrs. Lillian M. Page, Convention Chairman, Veterans Administration Hospital, Martinsburg, West Virginia.

Medical Scholarship Booklet

The American Medical Association has published a booklet entitled "Medical Scholarship and Loan Fund Programs."

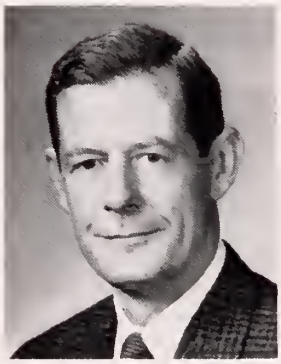
The 57-page booklet gives all pertinent information about scholarship and loan fund programs sponsored or administered by state and county medical societies and woman's auxiliaries.

14th Annual GP Scientific Assembly In Charleston, April 29-May 1

The 14th Annual Scientific Assembly of the West Virginia Chapter of the American Academy of General Practice will be held at the Daniel Boone Hotel in Charleston, April 29-May 1.

Dr. L. Dale Simmons of Clarksburg, general chairman of the convention, announced that 15 physicians and surgeons had accepted invitations to appear as

Dr. Stanley H. Martin



Wm. P. McKelway, M. D.

guest speakers. More than 200 physicians are expected to attend the three-day meeting.

Cancer Society Program

Dr. Jack Leckie of Huntington, the president, will call the meeting to order at 1:30 P.M. on Friday, April 29. The invocation will be given by the Rev. Alfred E. Bennett of Charleston and addresses of welcome will be given by Mayor John A. Shanklin of Charleston and Dr. Seigle W. Parks, President of the State Medical Association.

The scientific session on Friday afternoon will be devoted to a program sponsored by the West Virginia Division, American Cancer Society, and one of the speakers will be Dr. Thomas J. Hartford, Medical Affairs Representative of the American Cancer Society.

Speakers for Scientific Sessions

In addition to Doctor Hartford, the following physicians and surgeons will present papers at the general scientific sessions during the meeting:

Dr. Lewis K. Alpert, Professor of Medicine, George Washington University School of Medicine.

Dr. Erland Nelson, Professor of Neurology and Head of the Department, University of Maryland School of Medicine.

Dr. Leonard Scherlis, Division of Medicine, Department of Cardiology, University of Maryland School of Medicine.

Dr. Justus C. Pickett, Chairman, Division of Orthopedic Surgery, West Virginia University School of Medicine.

Dr. James I. Tennenbaum, Department of Medicine, Allergy Research Laboratory, Ohio State University College of Medicine.

Dr. David Simpson, Associate Professor of Medicine, University of Maryland School of Medicine.

Dr. Anthony F. Susen, Instructor in Surgery, University of Pittsburgh School of Medicine.

Dr. Thomas E. Cone, Department of Pediatrics, Harvard Medical School.

Dr. Hans C. Keitel, Professor and Head of the Department of Pediatrics, Jefferson Medical College.

Dr. William P. McKelway, Associate Professor of Obstetrics and Gynecology, George Washington University School of Medicine.

Dr. George Jones, Associate Clinical Professor of Obstetrics and Gynecology, Medical College of Virginia.

Dr. Richard K. Kirkland, Associate Professor of Medicine, Medical College of Virginia.

Dr. Jacqueline M. Harrison, Department of Medicine, Medical College of Virginia.

Dr. David B. Gray of Charleston.

Business Sessions Scheduled

A meeting of the Board of Directors will be held at the Daniel Boone Hotel on Thursday evening, April 28, and the House of Delegates will meet on Friday morning.

Dr. L. Dale Simmons of Clarksburg, the president elect, will be installed as president during the meeting, succeeding Dr. Jack Leckie of Huntington.

Other officers are Dr. Martha J. Coyner of Harrisville, vice president; Dr. Del Roy R. Davis of Kingwood, secretary; and Dr. C. Carl Tully of South Charleston, treasurer. Dr. Peter A. Haley of Charleston is chairman of the Board of Directors, and Dr. Carl B. Hall of Charleston, Editor of *Mister Doc*, official publication of the Chapter.

Thomas Cone, Jr., M. D.

Justus C. Pickett, M. D.

Banquet on Saturday Evening

Dr. Stanley H. Martin, President of West Virginia Wesleyan College, will be the speaker at the annual banquet which will be held at the Daniel Boone Hotel on Saturday evening.

An interesting entertainment program has been arranged for wives of physicians in attendance at the meeting.

PG Course In Otolaryngology

The Department of Otolaryngology of the University of Illinois College of Medicine will conduct its annual Otolaryngologic Assembly in Chicago, October 1-7.

Requests for additional information should be sent to the Department at P. O. Box 6998, Chicago, Illinois 60680.

W. Va. Cancer Society's Program For Patients Outlined

Two years ago, David B. Gray, M. D., Service Chairman of the American Cancer Society's West Virginia Division, announced a new simplified service program for cancer patients. This was reviewed by the Cancer Committee and copies of it were sent to Cancer Society members.

The program was based on three principles:

FIRST: West Virginia physician's diagnosis of cancer and that he wants the services for his patient he believes to be medically indigent.

SECOND: Only services available to all such patients be provided.

THIRD: That red tape and form filling be kept to a minimum.

The simplified application identifies the patient, indicates the diagnosis and the doctor's signature.

The listed services are rendered when requested by the physician. Invoices are submitted through the Society's county unit.

The Society does not pay hospital, doctor or nursing bills and directs its service to outpatient and home patient problems.

The extent of the service rendered by the Society is found in its latest report. During the last fiscal year, 98,425 dressings distributed, 1,438 loan closet items were provided, 4,879 prescriptions for drugs were purchased and 3,548 trips for outpatient transportation were made.

The transportation and medications are limited to $15 per month each for any patient but not by distance or type of medication.

There is no limit to the amount of dressings which may be requested. The home care items are generally based on those available from the local County Unit's loan closet. Hospital beds, bed pans and wheel chairs are typical of the items which are loaned.

These services are available in every part of our state. They indicate a substantial gain by the Society in the services it renders. A 100 per cent gain in medications and transportation has been registered since the new program was instituted. Doctor Gray states that there have been no listed services denied a cancer patient during the period of the new program.

Other Highlights of The Report

PUBLIC EDUCATION—Activities consisted of the distribution of nearly a half-million pieces of literature and 1,044 public education film showings. Primary emphasis on this area was early detection by the doctor. A list of films available for public showing include "Time and Two Women," (Uterine Exfoliative), "Breast Self Examination," "Life Story" (Proctosigmoidoscopy), and "Sense in the Sun" (Skin Cancer).

Non-smoking films "Who, Me?" for adults, "To Smoke or Not To Smoke" for teen-agers and the "Huffless Puffless Dragon" for earlier age groups. These films have been used widely through the schools and service clubs. Film strips for the same purpose have likewise been given to most secondary schools in the state for continuing education in this area.

PROFESSIONAL FILMS AND LITERATURE—References include monographs, reprints of published articles and leaflets for patient guidance and use.

Films of a professional nature are available for a private viewing by any physician as well as clinical or teaching lectures. Current updated titles include eight on diagnosis and treatment, one on proctosigmoidoscopy and six kinescopes of physicians conferences on cancer—oral, thyroid, colon and rectum, prostate, moles and melanomas and psychological aspects. All film showings and literature from the Society are available without cost or obligation.

The Society has an active county unit in nearly every county with Unit offices in 10 of the larger ones. Inquiries or requests are usually directed to these offices or to county unit leaders.

The West Virginia Division office is located at 325 Professional Building in Charleston (Telephone 344-3611) and is always ready to answer questions. The Executive Director, Bill Nichols, will be glad to assist you in getting any services, films or material.

Dr. Charles E. Andrews Lectures At Thoracic Meeting

Dr. Charles E. Andrews, Professor of Medicine at the West Virginia University School of Medicine, was among the speakers at the 14th Tri-State Conference on Pulmonary Diseases, which was held at Roanoke, Virginia, March 27-29.

Doctor Andrews discussed Diagnostic Problem Cases on March 29.

The conference was sponsored by the Thoracic Society of Virginia, North Carolina and West Virginia.

Former Auxiliary President Dies in Bluefield

Mrs. Ann Landon Scott Shanklin of Bluefield, former President of the Woman's Auxiliary to the West Virginia State Medical Association, died at her home on February 9. She was 91.

Mrs. Shanklin was the widow of Dr. Richard V. Shanklin, Sr.

ACP Course in New York City

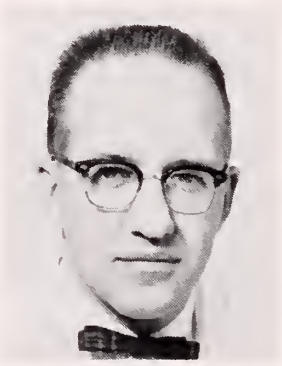
The American College of Physicians is sponsoring a postgraduate course in "Current Concepts of Renal, Gastrointestinal and Circulation Physiology" in New York City, April 14-16. The course is co-sponsored by the American Physiological Society.

Requests for application forms and additional information should be addressed to Dr. Edward C. Rosenow, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

Two Out-of-State Speakers on ACS Program at The Greenbrier

Two out-of-state physicians will be among the speakers at the annual meeting of the West Virginia Chapter of the American College of Surgeons which will be held at The Greenbrier in White Sulphur Springs, April 14-16.

Leonard Peltier, M. D.



Colin G. Thomas, Jr., M. D.

Dr. Edgar F. Heiskel, Jr., of Morgantown, the President, announced that papers will be presented by Dr. Colin G. Thomas, Jr., Professor of Surgery, University of North Carolina School of Medicine; and Dr. Leonard F. Peltier, Professor of Surgery, University of Kansas School of Medicine. They will present papers at each of the three scientific sessions and their subjects will be as follows:

Doctor Thomas: "Thyrotoxicosis in Different Age Groups," "Chronic Pancreatitis," and "Intestinal Obstruction in the Newborn."

Doctor Peltier: "Fat Embolism," "Complications of Fractures of the Pelvis," and "The Management of Patients With Multiple Fractures."

Other physicians who will present papers during the meeting are as follows:

"Postoperative Management Fluids and Electrolytes." —Bernard Zimmermann, M. D., Professor and Chairman of the Department of Surgery, West Virginia University School of Medicine.

"Idiopathic Retroperitoneal Fibrosis." — Ralph J. Holloway, M. D., South Charleston.

"Surgery in the Hemophiliac."—Thomas J. Tarnay, M. D., Instructor in Surgery, West Virginia University School of Medicine.

In addition to the speakers mentioned above, papers also will be presented by several other physicians and residents.

Doctor Heiskel will preside at the meeting and the other officers of the Chapter are Drs. T. P. Mantz of Charleston, Vice President, and Harry F. Cooper of Beckley, Secretary-Treasurer.

A cordial invitation to attend the meeting has been extended by the West Virginia Chapter to all practicing physicians in the State.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1966

April 13-16—W. Va. Academy Oph. and Otol., White Sulphur Springs.
April 13-16—Am. Radium Soc., Phoenix.
April 14-16—W. Va. Chapter, ACS, The Greenbrier, White Sulphur Springs.
April 15-17—Am. Soc. of Int. Medicine, New York.
April 18-22—ACP, New York.
April 21-23—W. Va. Soc. of Medical Technologists, Martinsburg.
April 25-28—Industrial Med. Assn., Detroit.
April 25-30—Am. Acad. of Neurology, Philadelphia.
April 25-29—Am. Col. of Allergists, Chicago.
April 27-29—Am. Ped. Soc., Inc., Atlantic City.
April 27-May 4—Maryland Med. Soc., Baltimore.
April 28-30—Va. Soc. of Oph. & Otol., Charlottesville.
April 29-May 1—W. Va. Chapter, AAGP, Charleston.

May 1-4—American Col. Ob.-Gyn., Chicago.
May 1—Am. Fed. for Clinical Research, Atlantic City.
May 2-5—Am. Col. of Ob.-Gyn., Chicago.
May 9-13—American Psychiatric Assn., Atlantic City.
May 11—Am. Cancer Soc., San Francisco.
May 18-22—Pa. Acad. of Oph. & Otol., Bedford Springs.
May 22-26—Am. Orthopaedic Assn., Colorado Springs, Colo.
May 22-27—Ohio State Medical Assn., Cleveland.
May 22-25—National TB Assn., San Francisco.
May 23-25—Am. Thoracic Soc., San Francisco.
May 30-June 1—Am. Ophthalmological Soc., White Sulphur Springs.
May 30-June 2—American Urol. Assn., Chicago.

June 2-4—American Gyn. Soc., Hot Springs, Va.
June 17-18—Am. Rheumatism Assn., Denver.
June 23-27—ACCP, Chicago.
June 24-25—Am. Geriatrics Soc., Chicago.
June 25-26—Am. Diabetes Assn., Chicago.
June 25—Am. Acad. of TB Phys., Chicago.
June 26-30—AMA Annual Meeting, Chicago.

July 7-9—Am. Med. Women's Assn., Rochester, N. Y.
July 10-14—Med. Women's Int. Cong., Rochester, N. Y.

Aug. 25-27—W. Va. State Medical Assn., White Sulphur Springs.
Aug. 29-Sept. 1—Am. Hosp. Assn., Chicago.

Sept. 8-10—Am. Assn. of Ob.-Gyn., Hot Springs, Va.
Sept. 9—Maryland Medical, Ocean City.
Sept. 16-24—Am. Soc. of Clinical Path., Washington.
Sept. 20-22—Kentucky Medical, Louisville.
Sept. 23-24—W. Va. Heart Assn., Morgantown.
Sept. 23-27—Col. of Am. Pathologists, Chicago.
Sept. 23-Oct. 1—Am. Soc. of Clinical Pathologists, Chicago.

Oct. 1-5—Am. Soc. of Anesthesiologists, Philadelphia.
Oct. 6—Rural Health Conf., Jackson's Mill.
Oct. 10-13—AAGP, Boston.
Oct. 10-14—ACS, San Francisco.
Oct. 15—Cabell County Symposium, Huntington.
Oct. 15-16—Am. Assn. of Oph., Chicago.
Oct. 16-21—Am. Acad. of Oph. & Otol., Chicago.
Oct. 21-23—Am. Heart Assn., New York.
Oct. 22-27—Am. Acad. of Pediatrics, Chicago.

Nov. 6-9—Med. Soc. of Virginia, Williamsburg.
Nov. 14-17—Southern Med. Assn., Washington.
Nov. 26-27—Am. Col. of Chest Physicians, Las Vegas.
Nov. 27-30—AMA Clinical Convention, Las Vegas.
Dec. 3-6—Am. Acad. for Cerebral Palsy, New Orleans.

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The Pathology of Bronchial Asthma Before and After Prolonged Steroid Therapy*

Leslie N. Gay, M. D.

When one reviews the reports of autopsies compiled by various investigators, it is obvious that asthmatic patients die from a variety of pathologic changes. Prior to death, the clinical diagnosis of asthma had been made in the majority of cases and, in most instances, asthma had been stated as the primary or secondary cause of death.

Anaphylaxis and Hypersensitiveness: Animal Pathology

As a basis for comparison of animal and human pathology, the original description of the lungs of an animal which had died from anaphylactic shock should be reviewed. This classical observation has established definite characteristics which assist in a better understanding of the pathologic physiology of this immunologic phenomenon. The major part of our knowledge of those manifestations of human hypersensitiveness grouped under the general term, "allergy," is based upon the fundamental principles of anaphylactic reaction in lower animals. Anaphylaxis, demonstrated in 1904 by Theobald Smith[1] is a term applied to a condition which is produced by the following experiment: If a small amount of horse serum, let us assume, 0.1 cubic centimeter, is injected into a normal guinea pig, no reaction occurs. After a sensitizing period of 14 days, however, if a second and larger amount, let us assume, 1 cubic centimeter, of horse serum is injected into a vein of the same animal, the animal immediately shows characteristic symptoms and usually dies in a few minutes after injection. The reaction thus produced is termed anaphylactic shock.

*Presented before the 10th Annual Potomac-Shenandoah Valley Postgraduate Institute in Martinsburg, Oct. 29-31, 1965.
Submitted to the Publication Committee, November 5, 1965.

The Author

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The findings of this classical observation were published in 1904. Weichardt[2] and Wolff-Eisner[3] in 1905, suggested that human hypersensitiveness and anaphylaxis were somewhat related. Hypersensitiveness refers to the condition which develops in an individual with many different types of symptoms whenever he comes in contact, whether by ingestion, injection, or by inhalation, with a certain substance normally harmless. For example, the majority of people can eat the white of egg in large quantity and have no discomfort from it; a few individuals, however, will react violently with characteristic symptoms to a minute quantity of egg white. This reaction is spoken of as *hypersensitiveness.* It is important to differentiate between *hypersensitiveness* and *idiosyncrasy.* The latter condition is exemplified by the tinnitus and other characteristic symptoms which develop after an individual has taken two or three tablets of quinine. To produce similar symptoms, the average individual would require 10 to 20 tablets of the same strength. On the other hand, the hypersensitive individual would have a violent reaction,—tinnitus, flushing of the face, itching of the skin, palpitation, perhaps even complete shock from a minute portion of a quinine tablet. Thus there is a quantitative difference in the physiologic response in idiosyncrasy compared

to the normal, but in the hypersensitive individual there is a pathologic reaction to a microscopic amount. The term, "*allergy,*" coined by Von Pirquet[4] in 1905, is defined as a changed reaction capacity which the human or animal organism gains through recovery from disease or through treatment with foreign substances.

Although human hypersensitiveness of the asthmatic type and animal anaphylaxis resemble each other, there are certain apparent peculiarities. First, the asthmatic type of hypersensitiveness occurs spontaneously in man, whereas animal anaphylaxis usually is induced in the laboratory. Thus far our present evidence is against the assumption that asthma occurs spontaneously in animals. Second, in human allergy, complete desensitization is most difficult and is rarely accomplished, whereas, in animal anaphylaxis, desensitization appears to be achieved more readily since repeated injections of very small doses of the sensitizing serum will finally desensitize the animal.

A guinea pig in anaphylactic shock shows a group of symptoms which are quite dramatic. Great restlessness is manifested within a minute after the intravenous injection; itching of the nose and eyes accompanies the restlessness; sneezing is produced. Respiration becomes deep and rapid, then more rapid but shallow. Next come a definite wheezing respiration and a slight cough. Soon sphincter control is lost; finally, the animal may fall to its side and, after a few convulsive contractions of the extremities and of the neck and chest muscles, it dies. When the chest is examined, there is great distention of the lungs and an observed engorgement of capillaries through the bronchial walls and the alveoli. There are numerous minute hemorrhages in the mucous membranes. When removed from the thoracic cavity, the lungs are not collapsed. There is some accumulation of moisture in the sectioned lung and some dripping of serosanguineous fluid. Microscopic study of the lung reveals emphysematous distention of the alveoli, engorgement of the alveolar capillaries, with great accumulation of red cells. The appearance of the heart is normal.

In contrast, the guinea pigs which were autopsied after recovering from prolonged shock showed a very different picture. The lungs were only slightly enlarged, occasionally even somewhat contracted. On the surface under the visceral pleura, there were patches of hemorrhages. Histological examination showed only slight or no emphysema. Edema between the peribronchial muscle and cartilage layers was very marked. Most conspicuous, however, was the widespread atelectasis. There was patchy interstitial infiltration of the alveolar walls with mononuclear cells; there was similar perivascular infiltration. In some of the lungs the alveoli contained exudate rich in eosinophils and the capillaries were crowded with polymorphonuclear leukocytes. Thus, just as the pathological picture of one anaphylactic pig might vary from that of another, so it is conceivable that human pathology will differ in patients who have died from bronchial asthma.

Human Pathology

Huber and Koessler,[5] in 1922, published a monograph on the pathology of bronchial asthma. This report of a series of cases was the most important contribution that had thus far been made, as surprisingly few recorded microscopic studies on this relatively common disease had appeared in the literature. In their monograph Huber and Koessler stated that it is a grave mistake to consider all cases of bronchial asthma as a manifestation of allergy. Subsequent work of many investigators strongly corroborates this opinion. The large group of patients having dyspnoea associated with asthmatic bronchitis may be influenced by bacterial allergy, but as yet there is no available scientific evidence which will substantiate the claim that all cases of asthmatic bronchitis are dyspneic because of bacterial sensitivity. Infection may produce difficult breathing in a variety of ways. For example, infection may involve the mucosa and the glandular structure; this involvement may produce an abundance of tenacious mucopurulent exudate which causes stenosis of the bronchioles and the alveolar spaces. Stenosis thus occurs and dyspnea is quite pronounced even without exertion by the patient.

Huber and Koessler[5] have added six cases to those reported prior to 1922, and these clinical data follow the pattern of the earlier cases. The youngest patient was 15 months, the oldest 55 years; sex was equally divided. In four cases duration of the disease was from five months to 19 years; in the other two cases (ages 17 and 32) the patients had suffered from childhood. Although bronchitis was the associated disorder in the six cases, only three patients died during an attack of asthma. It is the opinion of Huber and Koessler[5] that in these six cases of bronchial asthma the pathologic histologic examination of the finer structures of the bronchi and their branches suggests a certain parallelism between the clinical picture and the structural changes.

It should be emphasized that Huber and Koessler[5] have made a splendid contribution to

the pathology of asthma. The outstanding finding in their study is the evidence that the actual thickness of the walls of the bronchi and bronchioles of asthmatic patients was increased by more than 0.2 mm. outside diameter as compared with similar structures in nonasthmatic persons. This difference was due to the increased thickness of all layers from the epithelium to the outer fibro-cartilaginous layer. Increased activity of the glands, cellular infiltration of the wall, and hyperemia conjunctively led to swelling which could produce irritation of the peripheral nerve endings in the bronchial tube, thus indirectly causing bronchospasm. The abundant secretion of the hyperactive glands partially and in some instances completely obstructed the narrowed lumen of the middle-sized bronchi and the small bronchioles. Thus both systems, the exudative and the bronchomuscular, simultaneously played a part in the production of stenosis.

The chief cellular characteristic of the allergic reaction in man is eosinophilia. The eosinophilic infiltration of the bronchial wall in asthma is a characteristic histologic criterion of bronchial asthma, but it must be distinctly remembered that absence of eosinophilia does not exclude asthma. One should consider the presence of eosinophilia as one of the characteristic findings in allergic diseases but not necessarily a required finding in the diagnosis of such diseases. Huber and Koessler[5] suggested that the absence of eosinophilia might be construed as evidence in support of a theory that there is a type of asthma which may not be of allergic origin. Subsequent observation does not confirm this suggestion, for there are many cases of pollen asthma (recognized as a classical type of allergy) with normal eosinophil counts.

Of a group of 50 patients, Rachemann[6] believes that there are 28 of his cases which definitely suggest that prolonged fatal asthma does present a characteristic pathologic picture. In this group the disease began between the ages of 40 and 60. Asthma was the recorded cause of death. Autopsy revealed that the chronicity of the disease after it began was an important feature of the condition in so far as the pathologic anatomy was concerned. Each of these 28 patients died in a violent asthmatic attack, more severe and fatiguing than usual. To Rachemann,[6] the group demonstrated a definite picture because of the severity and the short duration of the disease; in several cases death occurred within a year; usually it occurs within two to five years. It may be recalled, however, that in animals pathological lesions of asthma can be produced in even shorter time. This selected group is a very small proportion of all cases in which the patient has died of asthma. Nevertheless, the macroscopic pathology suggests a characteristic picture, voluminous and overdistended lungs of a bluish gray color and all bronchi and bronchioles occluded with plugs of inspissated secretion. No cause of death other than this respiratory embarrassment was discovered at autopsy.

The pathologic consideration of asthma by Lamson and Butt[7] likewise deserves attention. These investigators further emphasize the fact that earlier students of asthma had inadvertently applied the term to a variety of disorders; consequently, the autopsy reports did not confirm the clinical diagnosis. They have reviewed a series of 48 cases in which the patients died, with the clinical diagnosis of asthma and they have concluded, after analysis of autopsy material, that the diagnosis of asthma was applied to such unrelated conditions as cardiac dyspnea, mechanical obstruction of the trachea, and pneumoconiosis. Lamson suggested that the terminology which best describes the condition is "paroxysmal dyspnea"; moreover, this terminology does not commit the medical student to any particular etiology.

A review of the records of The Johns Hopkins Hospital by Gay[8] reveals an interesting series of 24 cases in which the patients died after a clinical diagnosis of bronchial asthma and in which asthma was recorded either as the primary or secondary cause of death. Each of these cases has been studied in the Department of Pathology. The autopsy reports in these 24 cases are most instructive as there is a similarity between the anatomical diagnoses in these cases and the series of cases studied by Rachemann[6] and by Lamson[7] and his co-workers. The age of these patients varies from six months to 69 years; there were 14 males and 10 females. Three of the patients were under three years of age, and in each one the symptoms were violent and prolonged.

In the group of 24, there was less evidence that heredity played a part than in the majority of patients who suffer with allergic disease. Perhaps the figure is less accurate in the autopsied group, for many of the patients were not so certain concerning their ancestors as are patients drawn from private practice. In each instance a careful history had been recorded. Eight patients gave a positive family history; 16 gave a negative family history.

Associated allergic disease occurred in six cases; past history of eczema occurred in one of the infants; hay fever accompanied the asthmatic attacks in two cases. One patient gave a history of severe attacks of angioneurotic edema. Although he had had syphilis for which he was given adequate treatment, this treatment helped neither the asthma nor the edema. A patient with drug sensitivity had suffered with asthma for many years. For 10 years prior to death, he had known of his aspirin sensitivity, and managed to avoid the drug during the interval. His death followed the ingestion of an aspirin tablet which he powdered, then swallowed to relieve severe headache. Immediately status asthmaticus developed. Although after 48 hours he slowly improved, the pulmonary damage had been such that bronchopneumonia developed and soon terminated in his death. One of the patients had suffered with colitis and chronic arthritis for years. Some investigators believe that these are manifestations of allergy, but this belief could not be clinically substantiated in this patient.

The clinical and the anatomical diagnosis compare unfavorably. Fourteen cases had been clinically diagnosed as having marked emphysema. (The diagnosis of "overdistended lungs" would have been the correct terminology); 23 actually showed only overdistended lungs at autopsy. Prior to death, cardiac decompensation had been evident in nine cases; after death 15 revealed hypertrophied and dilated hearts (nine, right side; two, left side; four, right and left sides). Although only four patients had shown signs of pneumonia before death, the pathologist found 12 cases of pneumonia and 14 cases of chronic purulent bronchitis. Two of the patients had shown evidence of pulmonary tuberculosis; one was extreme. This case had been diagnosed prior to death, but the first case was inactive and physical signs were insignificant. Clinical signs of bronchiectasis had been observed in two cases; at autopsy three patients were found to have changes typical of this disease. In two of these cases the lesions were found in the terminal bronchi.

At autopsy one of the most constant findings was the obstructed bronchi. In 21 instances the macroscopic and microscopic examinations showed that bronchi and bronchioles were extensively filled with mucus, pus cells, eosinophils and bacterial organisms, dead and living. In a number of instances the entire lung was obstructed to the degree that only a limited amount of air-containing tissue was left to maintain the oxygen demand of the body. Chronic purulent bronchitis often was associated with these obstructed bronchi.

A detailed microscopic study of the lungs of these patients shows a characteristic pattern in many cases. One may subdivide the findings with reference to the bronchi and bronchioles, to the alveoli, and to the interstitial tissue and the glands.

The walls of the bronchi are consistently thickened and in practically all cases the muscles are hypertrophied. The basement membranes are hyalinized and lymphocytes, plasma cells, and eosinophils infiltrate the walls of most bronchi. The lumina of the bronchi contain polymorphonuclear cells, lymphocytes, and eosinophils. Squamous metaplasia of the epithelial lining of the bronchi is observed.

The alveoli show common findings: distention, in several instances dilatation with rupture of the walls, that is, a definite pathological emphysema, and areas of atelectasis alternating with areas of emphysema.

The interstitial tissue and the glands present the picture of hyperplasia and hyperactivity of the mucous glands; there are lymphoid follicles scattered in the interstitial tissue. Cellular infiltration with lymphocytes and eosinophils is a common occurrence.

Aside from the lesions characteristic of bronchial asthma (hypertrophy of bronchial muscles, infiltration of bronchial walls with lymphocytes, plasma cells, and eosinophils, basement membranes thickened by hyalinization, obstructed bronchi with purulent mucoid material, emphysema and atelectasis, hyperplasia and hyperactivity of mucous glands), other pathological changes enter into the cause of death. In any group of patients who have died from asthma the pathology is equally complicated. Infection (pneumonia) is a serious complication. Clinically it may be unrecognized unless an extensive area of lung tissue is involved. In this series of cases, pneumonia contributed most to the cause of death. Bronchi that have been obstructed by inspissated mucus for many months, or even years, resist infection feebly; oxygen exchange in asthmatic patients is inadequate. When infection further complicates the labored breath, excess secretion of glands and infiltration of cellular elements and bacteria into the bronchial lumen decrease still further the oxygen, and carbon dioxide increases until myocardial failure terminates life.

The pathology of bronchial asthma, like the pathology of other specific diseases, follows a

fixed pattern. When the clinical findings are such that the diagnosis of bronchial asthma is justified, one can assume that the lungs will be overdistended, that areas of atelectasis may be found, that the bronchi will be plugged with mucus and leucocytes, that in many patients the right side of the heart will be hypertrophied and dilated, and that heart failure may ultimately be the cause of death.

It is important to digress to report the pathology of asthma in patients with continuous asthma who have been treated with fairly large daily doses of corticosteroids over a prolonged period.

The continued use of steroids to control the paroxyms of chronic allergic bronchial asthma and of asthma associated with chronic bronchitis has many opponents. The danger of complications following prolonged use must always be considered. Likewise one must consider whether the great relief following continued steroid therapy in these patients justifies the risk. In the author's experience, careful following of the patient eliminates the danger.

A report of the pathology of corticosteroid-treated asthma has appeared in the literature during this past year. Keeney and Palmer[9] have reported the study of five cases of asthma coming to autopsy after an average of 4.4 years of therapy. In all of these cases, symptoms developed after the age of 40 years. Unlike the pathological picture of patients untreated with steroids, presented by Gay, the pathologic tissue alterations were (1) decrease in the inflamma-basement membrane prominence and smooth muscle hypertrophy of the bronchial and bronchiolar walls, (2) atrophy of the zona fasciculata of the adrenal cortices, (3) cystoplasmic hyalinitory reaction, the mucous gland activity, the zation and vacuolation of the pituitary basophiles and hyperplasia of the pituitary acidophiles, (4) atrophy of the lymphoid tissue of the spleen, (5) hypertrophy of the myocardial fibers and (6) slight and infrequent osteoporosis.

These changes certainly did not contribute to the death of these patients. The authors conclude that life was prolonged by the therapy and they believe "that long-term corticosteroid treatment is justified, that the favorable anti-inflammatory effect of corticosteroids on the bronchi and bronchioles probably accounts for an extended longevity. The other structural tissue changes related to corticosteroids seem to be lesser evils than the consequences of the disease." The author is in accord with this opinion.

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Trial by Jury

After months of hearing evidence in the case of the Government versus the makers and distributors of Krebiozen, a jury has found the defendants not guilty of causing the distribution of the substance "with the intent of defrauding the public."

This decision, however, whereas it removes the accused persons from legal jeopardy, does not alter the opinion of the Food and Drug Administration regarding the worthlessness of the product, or affect its decision to continue to bar Krebiozen from interstate commerce. The FDA, acting on the advice of its own inspectors and other consultants, including a group assembled by the National Cancer Institute, came to this inescapable conclusion in 1963.

It is in the power of the jury to free the defendants, but it remains the duty of the Food and Drug Administration to protect the public against a drug that has been proved worthless.—*The New England Journal of Medicine.*

Foci of Functional Endometrium In a Cervical Leiomyoma*

(Report of an Unusual Finding with Views on Histogenesis)

Raj K. Gupta, M.B.B.S., Enid F. Gilbert, M.B.B.S., and Dean R. Goplerud, M. D.

Ectopic foci of functional endometrium occurring in various locations in the human female have long been recognized. Prevailing opinions regarding their causation and mode of development, however, remain far from being completely understood.

Some aspects of the understanding of this fascinating condition date back to the writing of Von Recklinghausen and to discussions in Cullen's excellent monographs. Though ectopic foci of endometrium commonly designated as "endometriosis" have been reported in a variety of locations, they have not, to the authors' knowledge, been reported within a cervical leiomyoma. Leiomyomata within the uterus and separate foci of endometriosis, however, occur so commonly in the same patient that it has been suggested that the above two lesions may follow a common stimulant. (Gore: personal communication).

Because of the interest and fascinating presence of functional foci of endometrium within a cervical leiomyoma, it seemed of value to document the following case.

Case Report

The patient was a 47-year-old white female, admitted to the West Virginia University Hospital because of vaginal bleeding of two years' duration. The bleeding had been continuous for two weeks prior to admission and was accompanied by weakness and back pain. Prior to these symptoms, her menstrual periods were regular. Past history revealed that a left salpingo-oophorectomy had been performed for an unknown reason.

Pelvic examination revealed a 2.5 cm. pedunculated nodule protruding from the external os. A cystocele and rectocele were present. The uterus was symmetrically enlarged to the size of a 12- to 14-week gestation. The remainder of the physical examination was noncontributory except for mild pain in the left lower quadrant of the abdomen and moderate pallor of the nailbeds and conjunctivae. The hemoglobin was 8.2 Gm. per cent.

The nodule from the region of the external os was surgically removed and the patient was discharged, on iron therapy.

Five weeks later she was readmitted for definitive surgery. At this time her Hb. was 10.6 Gm. per cent. A hysterectomy and a right salpingo-oophorectomy were performed from which she made an uneventful recovery.

Gross Examination.—The nodule from the region of the external os measured 3 x 2.0 cm. It was moderately firm, tan-white and on cut surface had a whorled appearance. In the center, a tiny (0.2 cm.) red-brown area resembling a hemorrhagic zone was seen.

The uterus was symmetrically enlarged and weighed 160 Gm. The myometrium averaged 3 cm. in thickness and the endometrium 0.2 cm. In the anterior myometrium were numerous sharply circumscribed firm, gray-white nodules (similar to the one removed from the region of the external os) which measured up to 2.5 cm. in greatest dimensions (Figure 1). A few similar nodules were located in the subserosal region. On cut surface they had a whorled appearance with a few pinpoint areas of hemorrhage.

The cervix, right fallopian tube and ovary were not remarkable.

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Submitted to the Publication Committee, August 23, 1965.

Microsocopic Examination.—The nodule removed from the region of the external os was composed of loose to compact fibrocollagenous tissue with interlacing smooth muscle fibers. The stroma contained a few acute and chronic inflammatory cells and some medium sized blood vessels. In the central portion were two discrete foci of hyperplastic endometrial glands marginated by endometrial stroma in which there were areas of fresh hemorrhage. One of the glands also contained fresh blood within its lumen (Figures 2 and 3). Multiple sections from the cervix showed evidence of chronic cervicitis. The endometrium was hyperplastic with some extension of endometrial glands into the myometrium.

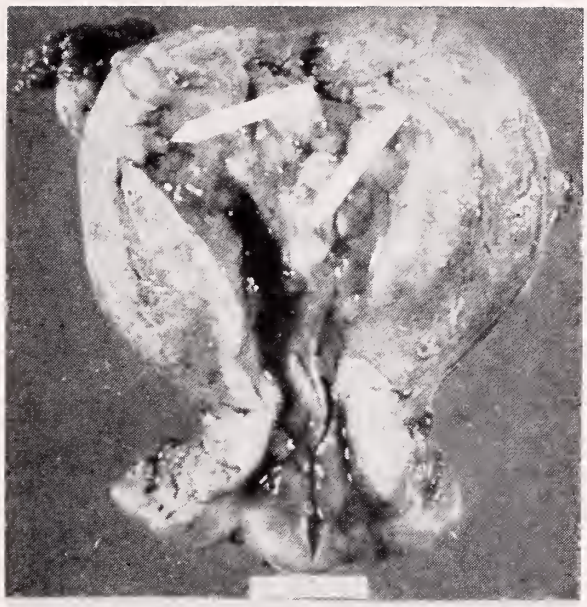

Figure 1. Gross specimen of uterus with multiple submucosal leiomyomata projecting into endometrial cavity.

Discussion

Numerous reports have been mentioned in the literature describing the occurrence of foci of ectopic endometrium in unusual locations. Though a number of theories have been proposed, none of these has ever justifiably explained the presence of ectopic endometrium in all the various locations where it has been found.

The first proponent of the "transplantation theory" was Sampson who, in his ingenius monographs, suggested the possibility of retrograde menstruation, resulting in shedding and transplantation of viable endometrial tissue into sites where external endometriosis occurred. His theory, however, could not explain the presence of ectopic endometrium in certain locations as, for example, in the umbilicus. In subsequent papers, Sampson, although still a proponent of his transplantation theory, agreed that in some cases this phenomenon could occur as a result of metaplasia of epithelium. As examples of these he cited endometriosis occurring in the region of amputated tubal stumps and at the endosalpingoperitoneal junctions. Halban,[6] in 1899, (later supported by Sampson) suggested that the transplants may possibly take place via lymphatic or venous channels.

The finding of endometrial implants in the ovaries prompted Russel to postulate that such implants could possibly represent persistence of mullerian rests. Sampson, in 1921, suggested that ovarian implants were best explained by regurgitation of endometrial fragments which had transplanted after their passage from the fimbriated ends of the fallopian tubes.

The theory of transplantation was much supported in recent years by experimental evi-

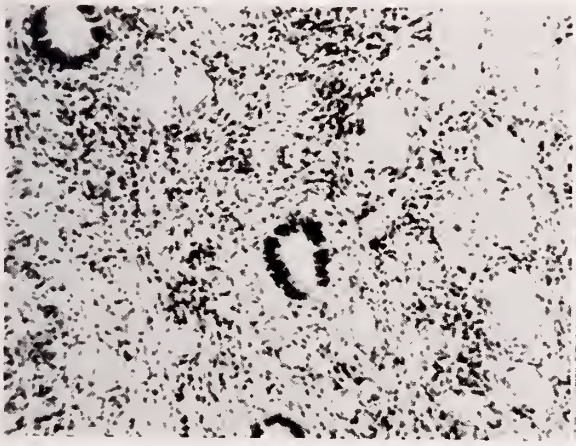

Figure 2

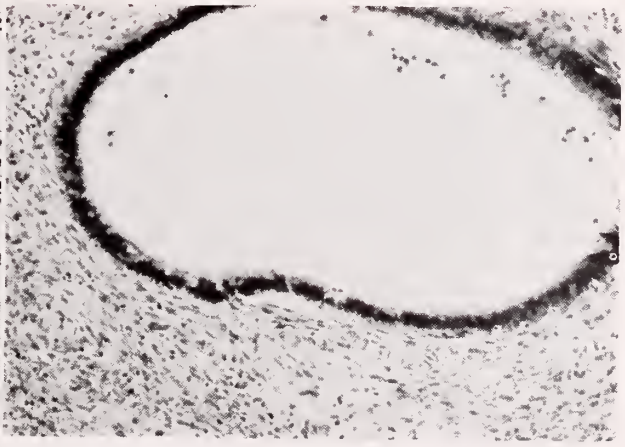

Figure 3

Figure 2. Cervical leiomyoma showing three foci of endometrial glands and stroma. Mag. X 40. (Figure 3) High power view of focus of endometriosis within the cervical leiomyoma. Mag. X 100.

dence.[7,17,26-30] In more recent years much emphasis has been given to the theory of Iwanhoff and Meyer (metaplasia of coelomic epithelium). According to some investigators,[2,11,13-15,34] the process represents, rather than a metaplasia, an abnormal differentiation of coelomic epithelium (which is the source of all developing genital organs). The stimulus initiating this abnormal differentiation may be related to inflammation, prolonged irritation or even a hormonal influence.

According to Willis, the peritoneum, with very few exceptions, is present in all locations where foci of ectopic endometrium are known to develop. In his opinion, the epithelial and nonepithelial or stromal components arise from a common precursor by metaplastic differentiation of coelomic wall tissue. According to Grunwald, the nonepithelial elements of ectopic endometrium develop from mesenchymal tissues adjacent to the coelomic epithelium.

Can metaplastic differentiation explain the presence of trapped foci of ectopic endometrium within the cervical leiomyoma of the present case? The answer to this is probably no, since the process of metaplasia and transformation of one cell type to another is an indirect one for which little convincing proof is available except for some primitive tissue culture studies. The persistence of embryonal cells throughout life and their metaplastic transformation has always posed interesting theoretical problems in the minds of biologists.

In recent years, the role of trauma, particularly that following operations of conization, cauterization and curettage, has been mentioned in reference to cervical endometriosis.[3,18,32,34] According to these theories, implants of viable endometrium grow at the site of the pre-formed granulation tissue following operative procedures, thus supporting Sampson's theory of transplanted ectopic foci of endometrium in this location.

In the case under consideration, the patient had vaginal bleeding for two years. This was undoubtedly related to the multiple leiomyomata as was evident from their presence in the surgically removed uterus. With such a persistent menometrorrhagia, it is conceivable and indeed feasible that at some stage in the course of the disease, transplantation of viable endometrial tissue took place via lymphatic or vascular channels, such endometrial emboli thus coming to lodge in the substance of the preexisting cervical leiomyoma.

Summary

A case of endometriosis occurring within a cervical leiomyoma is reported.

Various theories of the histogenesis of endometriosis are discussed.

This case is believed to support the theory of transplantation of endometrial tissue either via a lymphatic or vascular route into a preexisting cervical leiomyoma.

A list of references may be obtained by writing to The Journal.

The Federal Government Decides . . .

As of today, the Federal government may designate the official name of a drug product, if it is not satisfied with the originator's suggestion. The Federal government maintains surveillance over clinical research on the project, and can halt or redirect it at any time. The Federal government decides whether the product can be placed on the market. The Federal government decides when to permit its sale. The Federal government decides its method of distribution. And finally, the Federal government decides what can be advertised about the product.

It is still within the privacy of our industry to make two important decisions—whether to undertake laboratory research on a given product, and what to charge for a product.—C. Joseph Stetler, to Northern California Pharmaceutical Association.

Multiple Primary Malignancies: A Critical Review

(With Selected Case Histories)

Jack C. Fisher, M. D., and Alfred S. Ketcham, M. D.

The occurrence of more than one primary carcinoma in the same individual may no longer be considered a medical curiosity. Billroth[1] (1889) was the first to call attention to the possible coexistence of multiple cancers and, since then, numerous reports have attested to their frequency.[8,9,10,15,16] In the past 30 years, over 12,000 cases have been subjected to epidemiologic analysis and documented in the medical literature. Throughout this period, controversy has existed regarding the possibility of altered susceptibility to second malignancies. Many conclusions have been formulated, all of which are based on statistical analysis of one variety or another. Warren and associates,[15,16] in their comprehensive reviews (1932 and 1944), have reported an elevenfold increase in the incidence of second malignancies in patients who have already experienced cancer. Peller (1941),[12] however, concluded that "A cured tumor leaves protection of the body against the development of other malignant neoplasms." So convinced was he of his findings that he advocated the artificial production of cutaneous cancers by radiant, chemical or mechanical methods in order to prevent the subsequent development of more lethal malignancies.[11] In his subsequent reports,[13] he claimed a 90 per cent decrease in cancer mortality with these methods, but no confirmation of these observations has ever been published by other investigators. Epstein[3] (1960) reviewed the cases of 3,885 patients with skin cancer, and admitted he could manipulate the findings either to prove or disprove Peller's claim, depending on the care he exerted in selecting control groups. Such manipulations are often suspected by the reader of medical literature although proof is frequently difficult to obtain. Perusal of Epstein's[3] amusing and candid report is, therefore, worthwhile and instructive.

Since the classic reports of Warren,[15,16] other investigators have realized that patients in whom multiple primary cancers have developed must be subdivided into homogeneous groups. Moertel[10] has recognized at least three such categories: 1. Primaries of multicentric origin involving either the same organ or tissue, common or contiguous tissue shared by different organs, or bilateral paired organs. 2. Multiple primaries of unrelated organs or tissues. 3. A combination of the first two groups. Mider[9] (1952) and Watson[17] (1953) were the first to point out that unrelated second malignancies do not occur with increased frequency in previously treated cancer patients, but that neoplasms of multicentric origin most certainly do. The most common examples are neoplasms of the skin, oral cavity,[7,14] testis,[4] large intestine and female genital tract. In addition, a significant number of multiple primaries of multicentric origin are derived from premalignant conditions such as gastric polyposis, ulcerative colitis and cryptorchidism.

Submitted to the Publication Committee, December 29, 1965.

The Authors

- **Jack C. Fisher, M. D., and Alfred S. Ketcham, M. D., Surgical Branch, National Cancer Institute, National Institutes of Health, Bethesda, Maryland.**

We have recently examined the records of patients with multiple cancers who have been treated at the Surgery Branch of the National Cancer Institute. Several findings are worthy of emphasis, as demonstrated in a number of representative case histories.

Criteria for Study.—Patients who gave a history of previous malignant disease were included if microscopic confirmation of the disease was available. Criteria for the diagnosis of multiple malignancies were identical with those first set down by Billroth[1] and later modified by Warren and Gates[16]: 1. Each tumor must exhibit definite histologic criteria for malignancy (*in situ* lesions discarded). 2. Each primary must be a distinct entity. 3. The likelihood that one lesion is a metastasis from the other must be excluded.

Findings

Eighteen patients were considered suitable for inclusion by these criteria. Fourteen had experienced double malignancies and three exhibited three separate neoplasms. The remaining

patient had been treated for three multicentric lesions of the skin and two unrelated carcinomas of the parotid and prostate glands. In Table 1, the patients are listed in two groups; first, the 11 patients with unrelated primaries and, second, the seven with at least two tumors arising from similar organs or tissue. A preponderance of pelvic, head and neck malignancies will be noted since lesions of these regions are most commonly referred to the National Cancer Institute for surgical treatment.

No attempt was made to establish the incidence of multiple primaries at this institution, because these patients were part of a highly selected population with advanced malignancy referred to a center which attracts not only unusual diseases but also lesions which often have been resistant to previous therapy. Previous studies[2,5,6,8,10,15,17] report a multiple cancer incidence ranging from 1.2 per cent to 7.8 per cent. Most of these reports, however, involve either autopsy series or data derived from surgical reports, and are therefore not transferrable to the general population. Only one recent study has involved a community analysis, namely, that of Mersheimer[8] et al (1964) who assembled data from the listings of the Connecticut Tumor Registry and found a 3.2 per cent incidence of multiple malignancy. This probably represents the best available series reflecting the true incidence of multiple cancers.

The average age of the 18 patients in our series was no different from what might be expected in any cancer population. The mean age for the appearance of the first primary was 53 and for the second, 57. Contrary to our mean interval of four years, Mersheimer[8] reports that the patients in approximately one-half the cases in his series exhibited evidence of the second primary within 13 months of the first.

It is noteworthy that four patients had more than one cancer in estrogen-sensitive organs (i.e., breast, cervix, corpus uteri and vagina). No evidence, however, has ever proven an endocrinologic basis for multiple malignancies. It is extremely difficult to evaluate double primaries of the breast because of the possibility that delayed development of a contralateral lesion may represent metastatic disease.

Ten of the 18 patients are alive and free of malignancy (follow-up ranging from 1 to 11 years with a mean of 3.3 years).

Case Reports

Case 1.—L. K., age 54, had received radiotherapy for stage 1 epidermoid carcinoma of the cervix three years previously. At the time of admission, the patient complained of rectal bleeding and examination revealed a localized squamous cell carcinoma of the ano-rectal junction. Additional bleeding was noted from the region of the residual cervical os. Biopsies revealed recurrent cervical carcinoma. Following total pelvic exenteration, study of the excised specimen substantiated the impression that two distinct malignancies existed. The patient is alive and free of disease two years later.

Case 2.—K. K., age 48, had noted vaginal bleeding for approximately three months. Pelvic examination and biopsies revealed an ulcerated epidermoid carcinoma of the cervix. Upon further questioning, however, the patient commented that blood often had been mixed with her stool. Sigmoidoscopy and barium enema examination revealed a separate adenocarcinoma of the rectum. Both lesions were removed at one time by total pelvic exenteration but the patient died during the postoperative period.

Comment.—Both cases illustrate the possible simultaneous existence of two primaries, each contributing to the symptom complex. During physical examination, a high index of suspicion should be maintained that more than one lesion exists.

Case 3.—J. L., age 59, underwent radical hysterectomy for stage II epidermoid carcinoma of the cervix. At the time of exploration, a firm, yellowish nodule was noted at the tip of the appendix. Appendectomy was done and examination revealed the presence of a malignant carcinoid tumor. The patient is free of disease five years later.

Case 4.—J. F., age 50, underwent total pelvic

Table 1
Patients with Multiple Primary Malignancies

A. Primary Site of Unrelated Cancers (Order of Appearance)

G.B.	Rectum	Lymphoma	
N.B.	Corpus Uteri	Breast	
N.C.	Max. Antrum	Breast	
M.G.	Colon	Oral Cavity	Skin
C.H.	Larynx	Colon	
N.K.	Melanoma	Corpus Uteri	
K.K.	Cervix	Rectum	
J.L.	Cervix	Appendix	
M.L.	Larynx	Leukemia	
D.M.	Ilium	Cervix	
A.Q.	Cervix	Breast	

B. Primary Site of Multicentric or Related Cancers (Order of Appearance)

J.F.	Cervix	Vagina	
J.H.	Oral Cavity	Larynx	Lung
L.K.	Cervix	Anus	
L.P.	Cervix	Corpus Uteri	
R.P.	Skin (3)	Parotid	Prostate
E.M.	Oral Cavity	Oral Cavity	Colon
E.S.	Cervix	Vagina	

exenteration for stage III epidermoid carcinoma of the cervix. Prior to surgery, a 0.5 cm. nodule had been noted in the vaginal fornix but was not specifically biopsied. Examination of the resected specimen revealed a very unusual lesion, namely, an adenocarcinoma of the vagina in addition to the aforementioned cervical squamous cancer. A most interesting finding was that the epidermoid lesion was limited to the uterus and adjacent structures, but the small vaginal carcinoma had metastasized to several pelvic lymph nodes. The patient is well and free of recurrence two years later.

Comment.—Again, attention is called to the need for careful examination, even at the time of exploration, for the possible existence of additional primary lesions.

Case 5.—N. C., age 38, had undergone excision of what appeared to be an x-ray induced fibrosarcoma of the maxillary antrum five years previously. During a routine follow-up examination, a small lump was noted in the left breast, and biopsies revealed adenocarcinoma. The patient underwent left radical mastectomy and is free of malignancy three years later.

Case 6.—A. Q., age 50, had undergone total pelvic exenteration for advanced carcinoma of the cervix 10 years before. During a follow-up visit, breast examination revealed a slight degree of bleeding from the nipple but no mass was felt. At surgery, a small intraductal papillary carcinoma was discovered and radical mastectomy was done. Metastases were found in two axillary nodes. The patient is alive with no evidence of metastatic disease two years later.

Case 7.—E. M., age 74, had previously undergone both x-ray and surgical treatment for two separate epidermoid carcinomas of the oral cavity. During a visit to the clinic, a history of melena was elicited and barium enema examination demonstrated a carcinoma of the descending colon. Left hemicolectomy was subsequently done. The patient died one year later of metastases from both primaries.

Comment.—Careful follow-up with frequent visits is a *sine qua non* of adequate treatment for the cancer patient. Each such examination must include investigations directed to the possible existence of a new primary. Follow-up visits at the National Cancer Institute often are necessarily infrequent because of distance from the patient's home. We are, therefore, highly dependent upon the frequent and careful examinations of the referring physician. Return visits to the patient's local family physician are always emphasized prior to discharge.

Case 8.—N. K., age 68, had undergone three excisions of cutaneous malignant melanomas over the past eight years. At the time of admission, the patient complained of vaginal bleeding and, after a diagnosis of adenocarcinoma of the endometrium had been made, radical hysterectomy was done. The patient is alive and free of disease 11 years later.

Case 9.—J. H., age 58, has now undergone surgical excision for three separate malignant lesions over the past nine years, namely, epidermoid carcinoma of the floor of the mouth, epidermoid carcinoma of the larynx and adenocarcinoma of the lung. He is alive and free of disease one year following a pulmonary lobectomy and has now resumed his previous work.

Comment.—The final two cases illustrate the need for an aggressive attitude toward each malignancy. As experience accumulates, maintenance of an aggressive approach rather than an attitude of defeatism has yielded surprisingly favorable results. Assuming that the original cancer is adequately controlled, we feel that the appearance of a second or third primary should not contraindicate the same therapy which would be applied if each appeared alone.

Summary and Conclusions

1. Eighteen cases of multiple primary malignancies treated surgically at the National Cancer Institute have been reviewed.

2. The recent medical literature suggests that the risk of cancer patients incurring a second unrelated malignancy is no greater than the accepted incidence of neoplasia in the general population. Multiple malignancies of related organ and tissue systems, however, occur at a significantly increased rate.

3. The importance of careful examination and adequate follow-up of cancer patients, together with maintenance of a high index of suspicion for the possibility of multiple primary malignancies, is considered essential.

4. If the first malignancy has been satisfactorily controlled, subsequent primaries should be treated with the same aggressiveness as would be applied if each occurred alone. Utilizing this policy, 10 of 18 patients with multiple malignancies are alive and free of disease one to 11 years later.

A list of references may be obtained by writing to The Journal.

Flagyl destroys trichomonads

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Flagyl eliminates the difficulties and frustrations that have long attended the treatment of trichomonal infection.

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Complete blood cell counts should be made before and after therapy, especially if a second course is necessary.

Infrequent and minor side effects include: nausea, unpleasant taste, furry tongue, headache, darkened urine, diarrhea, dizziness, dryness of mouth or vagina, skin rash, dysuria, depression, insomnia, edema. Elimination of trichomonads may aggravate moniliasis.

Dosage Forms

Oral—250-mg.tablets/Vaginal—500-mg.inserts

SEARLE

Research in the Service of Medicine

The President's Page

THOSE WHO SERVE

THERE is no higher calling than one who serves his fellowman. From time immemorial the physician has served his patients, and to him has come great honor as well as great responsibility. In return the physician occupies one of the highest positions of esteem in the hearts and minds of his people. But new days are upon us, and with courage and wisdom the physician can continue to serve his fellowman, but there will be new challenges and there will be small men of little courage who will try to defile and to defame the physician, and he must be met and dealt with as the situation demands.

Today, I speak of those men who serve you as members and chairmen of the committees of the West Virginia State Medical Association. They are many, and their knowledge and experience has been gained after many years of service to their county medical societies as well as the State Medical Association. They have proven on many occasions that we can well place our trust in their capable hands. In them we know that our interests and the work of the Association will be carried out to the best of their abilities and dedication.

Hundreds of hours of serious consideration and discussion go to make up the many important decisions that will cover but few pages in *The Journal*, but without them there would be no *Journal*, or in fact no organization. In the background assisting and arranging in their planning are the skillful hands of our proficient Executive Secretary, Mr. William H. Lively, and his most capable assistant, Mr. Edward D. Hagan, and our limited but efficient office staff. We owe all of them a real debt of gratitude.

The purpose of this editorial is not to thank them, although they all deserve our most sincere gratitude, but the point which I wish to make is that in every worthwhile organization it is the combined work of many people, welded together for a common purpose, that develops the image by which the organization is known.

It is with pride that I state that the image of the West Virginia State Medical Association is strong and held with respect from within and without the profession. It is entirely due to those who serve and work for the purposes and principles for which we stand.

Seigle W. Parks, M. D., President

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EDITORIALS

THE RULES OF THE GAME

As this piece is being written, it is reported by *The AMA News* that practically all regulations for the operation of Part A of Title XVIII, PL 89-97, have been finalized. The regulations for Part B are now in the discussion stage between representatives of government, intermediaries and organized medicine; these discussions cover both overt and inferential factors which are of interest and concern to participating physicians. It must be remembered that the items herein named are *not* finalized regulations—they are simply current lines of thought which may or may not be established as the rules under which we will operate come July 1.

Inasmuch as this article is of primary interest to West Virginians, we shall use the term Nationwide, the appointed intermediary for this State, rather than the general term.

The most important function of Nationwide is to determine reasonable charges and make payment for services covered. The law requires that customary charges for similar services, as well as the prevailing charges in a particular locality for such similar services even though the patient is not eligible for Medicare, must be considered. The law then follows with a possible left hook to the jaw of realism—Nationwide shall allow the same charges for comparable service under comparable conditions which are paid to present policyholders of that company. From this provision there might be projected the possibility of using a schedule of charges contained in a low premium cost policy now in force as a standard for determining a reasonable charge under Medicare.

Prior to June, Nationwide must gather, organize and submit to the Social Security Administration complete information on customary and usual charges for each of the multitude of services rendered in different localities of the State, taking into consideration the variables between rural and urban areas and between smaller and larger metropolitan areas, and is then obligated to keep this information in a current status. This initial report shall contain the determination of reasonable charges with respect to (1) customary charges by physician and by procedure, (2) prevailing charges by locality and by specialty, and (3) existing policies issued by Nationwide which could limit the charge for services rendered to a comparable charge for comparable services under Medicare to its own policyholders.

The requirement that specialty status of the individual physician shall be considered in setting a reasonable charge could well be projected into a condition wherein physicians would be encoded as to alleged professional capability. One can envisage the determination by Nationwide Mutual that in the case of three individual physicians rendering the identical service to

three beneficiaries, one physician shall be coded as board certified, the second as board qualified but not certified, and the third as neither board certified nor qualified. The occurrence of such coding by an agent who acts for the government would surely bring forth recriminatory discussion and reaction.

Of further interest is the suggested source of information upon which the determinants are based. These sources are mentioned as (1) contact with local medical societies, (2) reference to fee schedules published in contracts in current force, and (3) by inspection of a physician's office records. There is specific mention of the inadvisability of accepting unsupported information from a physician. Could it be that Nationwide might be allowed the same access to records as is now enjoyed only by the Internal Revenue Service or by legal order of a state or federal court?

From these sources Nationwide must submit (1) a break-down of charges taken from urban, rural or metropolitan areas, (2) a break-down of medical charges in terms of the initial hospital visit and subsequent visits, as well as initial, routine and brief office visits, and (3) a break-down of charges made by specialists according to geographical areas and the services rendered.

The term "fee schedules" in existing policies and the use of a relative value index in setting maximum limits appears frequently in the published discussion notes. The California Index is mentioned favorably.

There is another item which might well be mentioned. In the lexicon of the procreators of the Great Society there has been a consistent determination that the words "means test" is a filthy expression which shall be forever abolished from the nomenclature of any group which embraces any degree of socialistic philosophy. Although the means test is specifically forbidden in the current discussion, we recall a recent meeting in which a representative of Nationwide very neatly skirted the fringe of semantics by using the term "economic status of the individual" in the determination of benefits. He did not deny any similarity or comparison between means test and economic status, which in itself lends an air of pre-determined inconsistency on the part of government or intermediary, or both.

When they are winnowed from this wide field of surmise, conjecture, facts, figures and possibilities, the finalized regulations of Part B will no doubt be detailed and complicated, but it is hoped that our participating physicians will be forthright, active and constructive in the conduct of our responsibilities in the operation of Medicare.

WOMEN IN U. S. MEDICAL SCHOOLS

The place of women in the study and practice of medicine has been a controversial subject. This was true especially in earlier years, but much less so during the past several decades in which there has been a pronounced increase in the number of women studying medicine. Recently the Association of American Medical Colleges has published a datagram which concerns the number of women enrolled in medical schools in the United States since 1930.

It is of interest to review by decades the number of women enrolled. In 1930 there were 955 which constituted 4.4 per cent of all students enrolled. In 1940, 1950, and 1960 the respective figures are: 1,145 (5.4%); 1,806 (7.2%); 1,710 (5.7%), and in 1965 there were 2,503 which constituted 7.7 per cent of all students enrolled. The number of acceptances to medical schools in 1929-1930 of women was 4.5 per cent, but in 1964-1965 it was 9.1 per cent, which is roughly a 100 per cent increase.

It is noteworthy that women enrolled in medical schools throughout the country gave a satisfactory account of themselves academically. The percentage of entering men completing their medical work between the years 1949-1958 was 91 per cent; the figure for women was 84 per cent. The majority of men dropped out of medical school because of academic problems, whereas slightly more than one-half of the women leaving medical school did so for reasons other than academic difficulty.

Since there is a growing shortage of medical personnel in this country and also because several new medical schools are being developed it is likely that even greater numbers of women may in the future consider medicine as a career. It is true that in the practice of medicine the activity of women physicians may be somewhat restricted by marriage and the responsibilities of the home. On the other hand, there are many women who raise a family and still are able to devote a good deal of their time to the practice of medicine; this is especially true after their children have grown to maturity.

SB 2568—A THREAT TO RURAL PRACTICE

United States Senate Bill 2568, "A Bill to strengthen the antitrust laws by prohibiting the payment to or receipt by persons licensed to engage in the practice of medicine, of profit, rebates, refunds, commissions, discounts, rentals or other valuable considerations in connection with the supplying to patients drugs, devices, or other products prescribed by such licensees," states this act may be cited as the Medical Restraint of Trade Act.

The Bill states "The Congress finds and declares that the payment to and receipt by persons licensed to engage in the practice of medicine, of profit in connection with the furnishing to patients of drugs, devices, or other products prescribed for consumption or use by patients tends to lessen competition and substantially to restrain and to monopolize trade and commerce and constitutes a burden upon interstate commerce in such products" and goes on to say under Section 4A—"It shall be unlawful for any person to pay, offer to pay, or allow, directly or indirectly, to any licensee, or for a licensee to knowingly receive directly or indirectly, any profit for or in connection with the referral of patients of the licensee to such person for the furnishing of any drug or device." The act defines "Licensee" as any person licensed in the practice of medicine.

Here is another choice example of a governing body, without rhyme or reason, establishing an act of prohibition that will deny practitioners of medicine, urban or rural, the right to dispense any drug or device to anyone except in unit dose. This bill represents further enslavement of a profession to the prejudices of any elected representatives.

The bill also denies the small pharmaceutical company the right to serve any dispensing physician.

It is recommended that all members, whether dispensing physicians or not, secure this bill and read it carefully.

In West Virginia where dispensing pharmacies may be 50 miles apart, the needy patient will have to return to the physician's office B. I. D. or Q. I. D., depending on his medical needs, because the law states only a unit dose may be dispensed at one time.

We have a great hue and cry in the land and especially in West Virginia for more rural practitioners. Passage of this bill will permanently squelch "Project ADAM" and all other local projects that seek to indoctrinate the physician to the joy and satisfaction of country practice. In many rural areas the right to dispense medicine is an inalienable function of the physician.

In the befuddlement of Medicare one thing is crystal clear—members of Congress and the Federal Administration have a total unconcern for physicians' opinions. So, we do not suggest that you write letters to your representatives but we do hope that our pharmacy and legislative committees will study the bill and establish liaison with our State pharmacists to determine if and why the druggists desire such legislation.

STEROID THERAPY IN THE TREATMENT OF ASTHMA

Our readers will enjoy and appreciate the manuscript of Dr. Leslie N. Gay in this issue of *The Journal*. The subject "Pathology of Bronchial Asthma Before and After Steroid Therapy" is of interest to all practitioners. The end result of prolonged steroid therapy is of great concern in the therapy of this common ailment.

In the treatment of bronchial asthma the use of steroid therapy is a matter of controversy even among specialists. No physician wishes to use Cortisone haphazardly and all recognize the consequences of the abuse of this treatment. Not infrequently, however, a small dose of Cortisone is, to the asthmatic, the difference between utter distress and the joy of living. Practitioners who have exhausted all their therapeutic facilities in the treatment of intractable asthma find the steroids a veritable anchor.

Of the five autopsied cases of Keener and Palmer reported by Gay and with whom Gay is in accord, the statement is made that "long-term corticosteroid treatment is justified and—the favorable effects on the bronchi probably accounts for an extended longevity."

The postmortem changes, which are reported in this article, indicate that the Cortisone therapy did not contribute per se to the death of these patients.

Digitalis—Would FDA Approve It Today?

". . . I would hate to be introducing digitalis as a new drug today. Anyone reading the toxicity and side effects would never use it in the present climate. However, digitalis has been with us long enough now that the toxicity and side effects have taken their proper place. They are there, to be sure, but not as prominently as the therapeutic effect.—Robert W. Ballard, M. D., in Food Drug Cosmetic Law Journal.

GENERAL NEWS

Drs. Greenblatt and Howell To Speak At 99th Annual Meeting

The Program Committee has announced that two prominent physicians have been added to the list of guest speakers who will appear on the program at the 99th Annual Meeting at The Greenbrier in White Sulphur Springs, August 25-27.

Robert Greenblatt, M. D.

Doris A. Howell, M. D.

Dr. Carl B. Hall of Charleston, the Chairman, said that Dr. Robert B. Greenblatt of Augusta, Georgia, and Dr. Doris A. Howell of Philadelphia have accepted invitations to present papers during the three-day meeting.

Robert B. Greenblatt, M. D.

Doctor Greenblatt, who is Professor and Chairman of the Department of Endocrinology at the Medical College of Georgia, will appear as a speaker at the first general scientific session on Thursday morning, August 25.

Doctor Greenblatt, a native of Montreal, Canada, received his M. D. degree in 1932 from the McGill University Faculty of Medicine. He took postgraduate work in pathology in Montreal and Boston and also served a residency in obstetrics and gynecology at University Hospital in Augusta.

He has been associated with the Medical College of Georgia since 1935 and at one time served as Assistant Professor of Pathology and Gynecology. Since 1946 he has served as Professor and Chairman of the Department of Endocrinology.

During World War II he served with the Medical Corps of the United States Coast Guard (Pacific Fleet) and now serves as consultant to the Office of the Surgeon General, United States Army, and the Veterans Administration.

He was certified by the American Board of Obstetrics and Gynecology in 1941 and is the author of a book, "Office Endocrinology," now in its fourth edition. He is the author of several other books and monographs and he has contributed numerous scientific articles to professional journals.

Doris A. Howell, M. D.

Dr. Doris A. Howell, Professor and Chairman of the Department of Pediatrics at the Woman's Medical College of Pennsylvania, will appear as a speaker at the second general scientific session on Friday morning, August 26.

A native of Brooklyn, New York, she was graduated from Park College and received her M. D. degree in 1949 from McGill University Faculty of Medicine.

She interned at Children's Memorial Hospital in Montreal, 1949-51, and served as senior assistant resident in pediatrics at Duke University Hospital, 1951-52. She had additional training at Harvard Medical School and Children's Medical Center in Boston, and served as Instructor in Pediatrics at Harvard Medical School.

She joined the faculty at the Duke University School of Medicine in 1955 where she remained until 1963 when she accepted her present position.

Doctor Howell was certified in 1956 by the American Board of Pediatrics and she is a member of the American Medical Association, American Hematology Society, New York Academy of Science and the American Academy of Pediatrics.

Program Nearing Completion

The names of several other guest speakers were announced previously. They are:

Gov. Hulett C. Smith, who will appear as a guest speaker prior to the opening of the first general scientific session on Thursday morning, August 25; and Dr. Charles L. Hudson of Cleveland, President Elect of the American Medical Association, who will be the speaker at the first session of the House of Delegates on Wednesday afternoon, August 24. Doctor Hudson will be installed as President of the AMA at the annual convention in June.

Other speakers who will appear on the program include Dr. James T. Priestley, who is head of a Section on Surgery at the Mayo Clinic and Professor of Surgery at the Mayo Graduate School of Medicine, University of Minnesota; and Dr. Robert I. Wise, Magee Professor of Medicine and Head of the Department of Jefferson Medical College.

Doctor Priestley will appear as a speaker at the first general scientific session on Thursday morning, August 25, and Doctor Wise will present a paper at the second general scientific session on Friday morning.

Pre-Convention Meetings

The pre-convention meeting of the Council will be held on Wednesday morning, August 24, and the first session of the House of Delegates on Wednesday afternoon. The final session of the House of Delegates will be held on Saturday afternoon, August 27.

Additional information concerning the program will appear in future issues of *The Journal*. The complete program will be published in the Convention Number in August.

Pediatric Society Conducts Spring Session

The West Virginia Pediatric Society held its 1966 Spring Session at the Honey in the Rock Motel in Beckley, March 31 and April 1.

Papers were presented by the following physicians:

Dr. Walter E. Bundy, Jr., Professor of Pediatrics at the Medical College of Virginia; Dr. William D. McLean, Beckley dermatologist; Dr. Barbara Jones, Associate Professor of Pediatrics at the West Virginia University School of Medicine; Dr. Russell V. Lucas, Jr., Associate Professor of Pediatrics at WVU; and Dr. Gwendolyn R. Hogan, Assistant Professor of Neurology and Pediatric Neurology at WVU.

Dr. Hugh Missildine of Columbus, Ohio, Research Editor for a pharmaceutical publication, addressed a banquet session. His topic was "Feelings and Their Medical Significance."

House of Delegates To Meet Twice at The Greenbrier

The Program Committee has announced that there will be two sessions of the House of Delegates during the 99th Annual Meeting of the West Virginia State Medical Association which will be held at The Greenbrier in White Sulphur Springs, August 25-27.

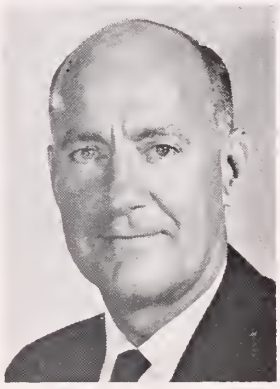
The first session of the House of Delegates will be held on Wednesday afternoon, August 24, the day preceding the formal opening of the Convention, and the final session will be held on Saturday afternoon, August 27.

The pre-convention meeting of the Council will be held on Wednesday morning and members of the Council have been urged to notify The Greenbrier immediately if they plan to register on Tuesday evening.

Delegates also are asked to arrange their schedules accordingly in order to be in attendance at the first session of the House of Delegates on Wednesday afternoon.

Dr. Edward R. Annis To Speak At 99th Annual Meeting

Dr. Edward R. Annis of Miami, Florida, a Past President of the American Medical Association, will be among the honor guests at the 99th Annual Meeting of The West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 25-27, 1966.



Edward R. Annis, M. D.

Doctor Annis, who in recent years has been one of the leading spokesmen for the medical profession, will be the speaker at a WESPAC meeting which will be held on Thursday night, August 25.

All physicians in attendance at the annual meeting, members of the Auxiliary and their families are cordially invited to hear the address by Doctor Annis.

A native of Detroit, Doctor Annis was graduated from the University of Detroit and received his M. D. degree in 1938 from Marquette University School of Medicine. He has served as Chief of the Department of Surgery at Mercy Hospital and attending physician at North Shore Hospital in Miami, Florida.

Doctor Annis has been active for many years in the affairs of local, state and national medical associations. He was named President Elect of the AMA during the Annual Convention in 1962 and was installed as President in June, 1963.

He is currently serving as a consultant to the AMA Advisory Committee on PL 89-97 (Medicare) and PL 89-239 (Regional Programs on Heart Disease, Cancer and Stroke).

Doctor Annis has many friends in West Virginia and has been a guest speaker at two previous meetings of the State Medical Association.

Cardiopulmonary Disease

The American College of Physicians will sponsor a postgraduate course on "Physiological Aspects of Cardiopulmonary Disease" at the Indiana University School of Medicine in Indianapolis, May 16-20.

The course is directed toward those physicians with particular interest in pulmonary disease and measurement of pulmonary function. It will deal with measurement of different aspects of pulmonary function, the functional derangement produced by different kinds of pulmonary and cardiopulmonary disease and with certain aspects of therapy.

Registration fees will be $60 for ACP members and $100 for non-members.

Requests for additional information and registration forms should be addressed to Dr. Edward C. Rosenow, Jr., Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

Public Health Association Meeting In Charleston, May 11-13

The West Virginia Public Health Association will conduct its 42nd annual State Health Conference in Charleston, May 11-13.

The theme of this year's meeting is "Closing The Gaps In Public Health: The 20th Century Challenge."

A meeting of the Executive Council on May 11 will be followed the next morning by the first general session. The keynote address on May 12 will be delivered by Mr. Ralph C. Pickard, Director of Environmental Health for the Kentucky Health Department. His topic will be "Environmental Health Challenges of Today."

Dr. Emil E. Palmquist of Charlottesville, Virginia, Regional Health Director for the U. S. Public Health Service, also will speak on Thursday, May 12.

Thursday afternoon will be devoted to meetings of the Association's various sections.

The first speaker on Friday morning, May 13, will be Mrs. Katherine B. Oettinger, Chief of the Children's Bureau of the U. S. Department of Health, Education and Welfare.

The Friday morning session also will feature a panel discussion of "Administering Hospital Insurance Benefits." The moderator will be Mr. Harry Parker, Director of Administration for the State Health Department's Health Insurance Benefits Unit.

Panelists will be Mr. Paul Jefferson, District Manager of the Social Security Administration; Dr. B. B. Richmond, Medical Director of the Health Insurance Benefits Unit; Mr. Robert Campbell of the Nationwide Mutual Insurance Company; and Mr. Don Maxwell, Medicare Coordinator of Blue Cross Hospital Services, Inc.

Additional section meetings will be held Friday afternoon.

The third general session will be held Friday evening in conjunction with the annual banquet. Speakers will include Dr. Roger P. Elser, President of the Association, and Mr. Guido Iannarelli, President Elect.

New officers of the Kanawha Medical Society were inducted at a meeting in Charleston on March 25 by Dr. Seigle W. Parks, President of the West Virginia State Medical Association (right). The new officers are (left to right): Dr. E. Q. Hull, Secretary-Treasurer; Dr. Joseph A. Smith, Vice President; and Dr. George R. Callender, Jr., President.

New Association Members

Dr. Stephen D. Dewing, WVU Medical Center, Morgantown (Monongalia). Doctor Dewing, a native of Princeton, New Jersey, was graduated from Princeton University and received his M. D. degree in 1945 from the Columbia University College of Physicians and Surgeons. He interned at Bellevue Hospital in New York City, 1945-46, and served residencies at Hackensack Hospital in Hackensack, New Jersey, and at the VA Hospital in Bronx, New York, 1948-53. He served for two years as a Captain in the Medical Corps of the United States Army and was previously located at the Hunterdon Medical Center in Flemington, New Jersey. His specialty is radiology.

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Dr. Joseph L. Farr, 2 Birch Avenue, Wheeling (Ohio). Doctor Farr, a native of Wheeling, was graduated from Georgetown University and received his M. D. degree in 1951 from Jefferson Medical College. He interned at the University of Illinois Research and Education Hospitals, 1951-52, and served residencies at the University of Pennsylvania and University of Iowa hospitals, and Walter Reed General Hospital. He was in military service for five years and was released with the rank of Major. His specialty is urology and general surgery.

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Dr. John S. Gruggel, American Viscose Company, Parkersburg (Parkersburg Academy). Doctor Gruggel, a native of Richfield Springs, New York, was graduated from Middlebury College and received his M. D. degree in 1937 from Long Island College of Medicine. He interned at Greenpoint Hospital in Brooklyn, 1937-39. He served with the Medical Corps of the United States Navy for 25 years and was retired in 1965 with the rank of Captain. He previously served as Industrial Medical Officer at the Norfolk Naval Shipyard in Portsmouth, Virginia. His specialty is industrial medicine.

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Dr. Lewis C. Reese, Fairmont General Hospital, Fairmont (Marion). Doctor Reese, a native of Ridley Park, Pennsylvania, was graduated from Group City College and received his M. D. degree in 1949 from the Hahnemann Medical College. He interned at Muhlenberg Hospital in Plainfield, New Jersey, 1949-50, and served residencies at the VA Hospital in Aspinwall, Pennsylvania, and West Penn Hospital in Pittsburgh. He served for three years with the Medical Corps of the United States Navy and was released with the rank of Lt. Commander. He was previously located in Waynesburg, Pennsylvania. His specialty is radiology.

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Dr. Hartwell G. Thompson, Jr., WVU Medical Center, Morgantown (Monongalia). Doctor Thompson, a native of Hartford, Connecticut, was graduated from Yale University and received his M. D. degree in 1950 from Cornell University Medical College. He interned at Bellevue Hospital in New York City, 1950-51, and served residencies at Hartford, Bellevue and Columbia Presbyterian hospitals in New York City. He was located at the University of Wisconsin School of Medicine prior to accepting appointment as Professor of Neurology at the West Virginia University School of Medicine.

Governor's Health Task Force Meets In Charleston

Gov. Hulett C. Smith's Task Force on Health met for the first time at the State Capitol in Charleston on March 30.

Addressing the group, the Governor said:

"The time is now for West Virginia to make new efforts to improve the home environment of our citizens and to assure all people the privilege of adequate health services."

Governor Smith made these observations: the average age of doctors in West Virginia is increasing; fewer doctors are willing to locate in rural areas; and many of the physicians who receive their medical education at the West Virginia University School of Medicine are moving out of state.

To provide adequate health services for all West Virginians might require as much as a four-fold increase in the number of persons engaged in health occupations, the Governor added.

Dr. Seigle W. Parks of Charleston, President of the West Virginia State Medical Association and a member of the Task Force, said most counties apparently have enough young people in premedical and medical education to meet local needs. But he said the chances are slight that many of these students will return to their home communities to practice.

About 30 of the 35 Task Force members attended the meeting during which State Institutions Commissioner Chauncey H. Browning, Jr., was elected permanent Chairman. Dr. Frank J. Holroyd of Princeton was elected Vice Chairman.

The following members of the West Virginia State Medical Association were named chairmen of Task Force Committees:

Doctor Parks, Committee on Manpower; Dr. Martha J. Coyner of Harrisville, Maternal and Child Health Care; Dr. James H. Walker of Charleston, Health Problems of Special Groups; and Doctor Holroyd, Public Health and Community Services.

Mr. Browning asked all committees to submit preliminary reports within 60 days.

The Task Force was enlarged to include two additional physicians. They are Dr. Earl L. Fisher of Gassaway and Dr. Harold H. Kuhn of Charleston.

Doctor Tow Presents Paper

Dr. Abraham Tow of Logan was a speaker at the meeting of the Association for Pediatric Ambulatory Services in Atlantic City, New Jersey, on April 26.

Doctor Tow's paper was entitled "Pediatric Practice and Clinical Research In An Isolated Rural Area."

The Association met prior to the meetings of the American Pediatric Society and the Society for Pediatric Research.

Dr. Edward R. Annis of Miami, Florida, (second from right), Past President of the American Medical Association, visited the Weirton area March 8-9. Doctor Annis addressed the Fort Steuben Academy of Medicine in Steubenville, Ohio, and visited Weirton General Hospital. Shown with Doctor Annis are (left to right): Dr. R. S. Greco of Weirton, President of the hospital's medical staff; Dr. E. J. Weller of Weirton, President of the Hancock County Medical Society; Doctor Annis; and Dr. Richard E. Flood of Weirton, President Elect of the West Virginia State Medical Association.

Action Due in August on Proposed Constitutional Amendments

Several amendments to the Constitution of the West Virginia State Medical Association, offered at the 98th Annual Meeting in White Sulphur Springs, August 26-28, 1965, will be acted upon finally by the House of Delegates at the 99th Annual Meeting at The Greenbrier, August 25-27, 1966.

The proposed amendments follow:

Article V

Sec. 1. Amend the section by deleting sub-section (2) and inserting in lieu thereof "all past presidents of the Association; and,". (The effect of this amendment would be to make all past presidents life-time members of the House of Delegates. Past presidents currently are members of the House for a period of 10 years following their tenure of office).

Article VIII

Sec. 2. Delete the entire section and insert in lieu thereof the following: "The place and dates for each annual meeting of the Association shall be selected by the Council." (Under the present Constitution, the place for the annual meeting is selected by the House of Delegates and the dates are selected by the Council).

Article IX

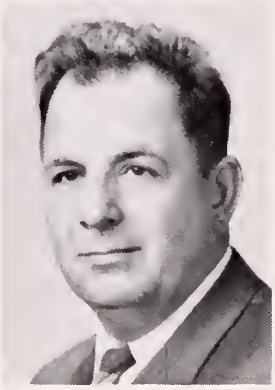
Sec. 2. Amend line 1 by inserting after the word, "Councilors," the words, "and the president." (Note: The president is not elected but is installed into office from that of the president elect).

Sec. 4. Amend line 5 by deleting the word "president," and inserting in lieu thereof the words, "president elect." (Note: If retiring president cannot be eligible for future election as president or vice president, neither should a past president be eligible for election as president elect.

Rheumatic Fever Symposium Planned In Bluefield

The Mercer County Medical Society will present a Symposium on Rheumatic Fever at the West Virginian Hotel in Bluefield, May 4-5.

Milton Markowitz, M. D.



Jean-Maurice Poitras, M. D.

The sessions have been approved for a total of five hours of Category I credit by the American Academy of General Practice.

Papers will be presented on Wednesday, May 4, by five physicians. Speakers and their topics will be:

"Prevention of Rheumatic Fever"—Allen Siegal, M. D., Associate Professor of Pediatrics, Northwestern University School of Medicine.

"Primary and Secondary Programs of Prophylaxis Against Rheumatic Fever"—Milton Saslow, M. D., Clinical Associate Professor of Preventive Medicine, University of Miami School of Medicine.

"Diagnosis and Management of Rheumatic Fever" —Milton Markowitz, M. D., Associate Professor of Pediatrics, Johns Hopkins School of Medicine.

"Surgical Management of Rheumatic Fever"—Herbert Warden, M. D., Professor of Surgery, West Virginia University School of Medicine.

Panel Discussion—Jean-Maurice Poitras, M. D., U. S. Public Health Service, Washington, Moderator.

The following day, Doctors Siegal, Markowitz, Warden, Poitras and Saslow will present, examine and discuss four specific cases.

Journalism Awards Program Announced By AMA

The American Medical Association has announced contest rules for its 1966 Medical Journalism Awards Program.

Awards of $1,000 and appropriately inscribed plaques will be made for distinguished reporting in each of five categories: newspapers, magazines, editorial, radio and television. The purpose of the program is to recognize journalism that contributes to a better public understanding of medicine and health in the United States.

Deadline for receipt of entries, which must be published or broadcast during the calendar year of 1966, is February 1, 1967. Winners will be recognized at the AMA's Annual Convention in June, 1967.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1966

May 1-4—American Col. Ob.-Gyn., Chicago.
May 1—Am. Fed. for Clinical Research, Atlantic City.
May 2-5—Am. Col. of Ob.-Gyn., Chicago.
May 9-13—American Psychiatric Assn., Atlantic City.
May 11—Am. Cancer Soc., San Francisco.
May 18-22—Pa. Acad. of Oph. & Otol., Bedford Springs.
May 22-26—Am. Orthopaedic Assn., Colorado Springs, Colo.
May 22-25—National TB Assn., San Francisco.
May 23-25—Am. Thoracic Soc., San Francisco.
May 24-28—Ohio State Medical Assn., Cleveland.
May 30-June 1—Am. Ophthalmological Soc., White Sulphur Springs.
May 30-June 2—American Urol. Assn., Chicago.
June 2-4—American Gyn. Soc., Hot Springs, Va.
June 17-18—Am. Rheumatism Assn., Denver.
June 23-27—ACCP. Chicago.
June 24-25—Am. Geriatrics Soc., Chicago.
June 25-26—Am. Diabetes Assn., Chicago.
June 25—Am. Acad. of TB Phys., Chicago.
June 26-30—AMA Annual Meeting, Chicago.
July 7-9—Am. Med. Women's Assn., Rochester, N. Y.
July 10-14—Med. Women's Int. Cong., Rochester, N. Y.
July 15-16—Rocky Mtn. Cancer Conf., Denver.
Aug. 25-27—W. Va. State Medical Assn., White Sulphur Springs.
Aug. 29-Sept. 1—Am. Hosp. Assn., Chicago.
Sept. 8-10—Am. Assn. of Ob.-Gyn., Hot Springs, Va.
Sept. 9—Maryland Medical, Ocean City.
Sept. 16-24—Am. Soc. of Clinical Path., Washington.
Sept. 20-22—Kentucky Medical, Louisville.
Sept. 23-24—W. Va. Heart Assn., Morgantown.
Sept. 23-27—Col. of Am. Pathologists, Chicago.
Sept. 23-Oct. 1—Am. Soc. of Clinical Pathologists, Chicago.
Sept. 30-Oct. 2—W. Va. Div., Am. Cancer Soc., Cacapon State Park.
Oct. 1-5—Am. Soc. of Anesthesiologists, Philadelphia.
Oct. 6—Rural Health Conf., Jackson's Mill.
Oct. 10-13—AAGP, Boston.
Oct. 10-14—ACS, San Francisco.
Oct. 11-14—Pennsylvania Medical, Pittsburgh.
Oct. 15—Cabell County Symposium, Huntington.
Oct. 15-16—Am. Assn. of Oph., Chicago.
Oct. 16-21—Am. Acad. of Oph. & Otol., Chicago.
Oct. 21-23—Am. Heart Assn., New York.
Oct. 22-27—Am. Acad. of Pediatrics, Chicago.
Oct. 31-Nov. 4—Am. Assn. of Public Health Physicians, San Francisco.
Nov. 6-9—Med. Soc. of Virginia, Williamsburg.
Nov. 14-17—Southern Med. Assn., Washington.
Nov. 15-20—Am. Medical Womens Assn., Washington.
Nov. 26-27—Am. Col. of Chest Physicians, Las Vegas.
Nov. 27-30—AMA Clinical Convention, Las Vegas.
Dec. 3-6—Am. Acad. for Cerebral Palsy, New Orleans.
Dec. 3-8—Am. Acad. of Dermatology, Bal Harbour, Fla.
Dec. 6-8—Southern Surgical Assn., Boca Raton, Fla.

1967

Jan. 14-19—Am. Acad. of Orthopaedic Surgeons, San Francisco.
March 9-11—AMA-ABA National Medicolegal Symposium, Miami Beach.
March 19-24—Southeastern Surgical Cong., Bal Harbour, Fla.
April 7-9—Am. Soc. of Int. Med., San Francisco.
April 12-15—W. Va. Acad. of Oph. and Otol., White Sulphur Springs.

The West Virginia Medical Journal

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Incidental Acute Focal Appendicitis In Incidentally Removed Vermiform Appendices*

M. Jamil Ahmed, M. D.

For some time, since the residency days in pathology, this observer has been aware of the presence of purulent exudate in the appendiceal lumens, occasionally with associated or demonstrable focal mucosal ulceration in some of the vermiform appendices removed purely incidental to abdominal or pelvic surgical procedures of various types. Such observations also have been made and recorded by others.[7, 11] Initially, there was a tendency to discard or ignore these observations since there wasn't enough stimulus to record or investigate them merely because the appendices were removed incidentally. Occasionally, the finding was added to the pathologic diagnoses as "presence of mild or moderate purulent exudate in the appendiceal lumen." Still, on occasion, it was felt necessary to let such an observation go on the record as "acute, focal appendicitis" despite the incidental nature of the appendectomy. This random observation of purulent exudate in appendiceal lumens became more challenging since this observer failed to find a satisfactory correlative (clinicopathological) explanation in the literature of clinical impact, if any, etiology, mechanism and pathogenesis of this histologic phenomenon. Certainly, this finding could not be explained on the traumatic (iatrogenic) basis, since the acute inflammatory reaction in such instances is found chiefly in the subserosal location.[2]

This observer also became aware of the fact that the histologic picture of "incidental, acute, focal appendicitis," as we've chosen to call it, was in no way dissimilar to "regular acute focal appendicitis" (though perhaps in some instances less marked in degree), well known to every pathologist who has (and who has not?) examined the histomorphology of vermiform appendices removed for and pathologically proven as acute appendicitis of early stages. This observation, which has now been noted in several of the appendices removed incidental to some other operative procedure, naturally resulted in several of the as yet not adequately explained and answered questions, at least on morphologic grounds. Continuous interest in this phenomenon resulted in accumulation of a sufficient number of cases to warrant justification and necessity of this paper. It is of interest to note that in the majority of positive cases, the intraluminal purulent exudate with or without associated focal ulceration of the mucosa, was found almost exclusively in the distal third of the organ.

The Author

- **M. Jamil Ahmed, M. D., Associate Chief of Pathology, Beckley Appalachian Regional Hospital, Beckley, W. Va.**

Materials and Methods

The study period is two years, starting in May, 1963. Five hundred and twenty-eight (528) consecutive incidental appendices removed at the Beckley and Man Appalachian Regional Hospitals (formerly Man and Beckley Memorial Hospitals) were submitted to routine histologic study, keeping in mind, however, the possibility of chance discovery of "incidental acute focal appendicitis." All these appendices were removed purely incidental to abdominal or pelvic

*Presented before the 1965 Spring Meeting of the West Virginia Association of Pathologists.
Submitted to the Publication Committee, December 31, 1965.

surgical procedures. A large number of the patients had elective surgical procedures and in none was there any clinical evidence or suggestion of acute appendicitis *per se*. The symptoms generally were relevant to the organ removed or repaired at the time of surgery (Tables 1 and 2).

Three or four sections, depending upon the length (two in the early part of the study), were examined from each appendix. In all, however, the distal third, or so, was bissected longitudinally with a clean sharp cutting edge to minimize the loss of luminal contents. The rest of the organ was cut transversely in the usual fashion, and a representative section of the body and proximal portion of the appendix obtained. All of these appendices were fixed in 10 per cent formalin and no special attention was paid to the time of fixation.

No correlative clinicopathologic analyses were made and the observations made were strictly in the light of histomorphologic study. Appendices removed on clinical suspicion of acute appendicitis and so proven pathologically were not included in this study, even though the histology was essentially similar to that noted in the present series. Likewise, cases with similar histology but removed as? clinical acute appendicitis were not used in this compilation.

It should be stressed that the 53 patients (Table 3) whose appendices revealed histologic changes of "acute focal appendicitis," and who parted from their appendices as an incidental procedure, had no clinical "appendiceal" problems and were, according to the clinical data charted, in perfect health insofar as the appendix was concerned. Incidental appendices that were diagnosed histologically as "chronic obliterative appendicitis" (fibrous obliteration) were discarded from the study.

Naked Eye and Histologic Observations

The appendices as a rule showed smooth, shiny, pink serosa with mild to moderate acute congestion of the subserosal blood vessels, particularly noted in the distal half of the organs. None of the appendices showed purulent exudate covering of the serosa. All these appendices were grossly described, both by the surgeon and the pathologist, as essentially normal.

Microscopically, the usually accepted criteria for the diagnosis of "early acute (occasionally

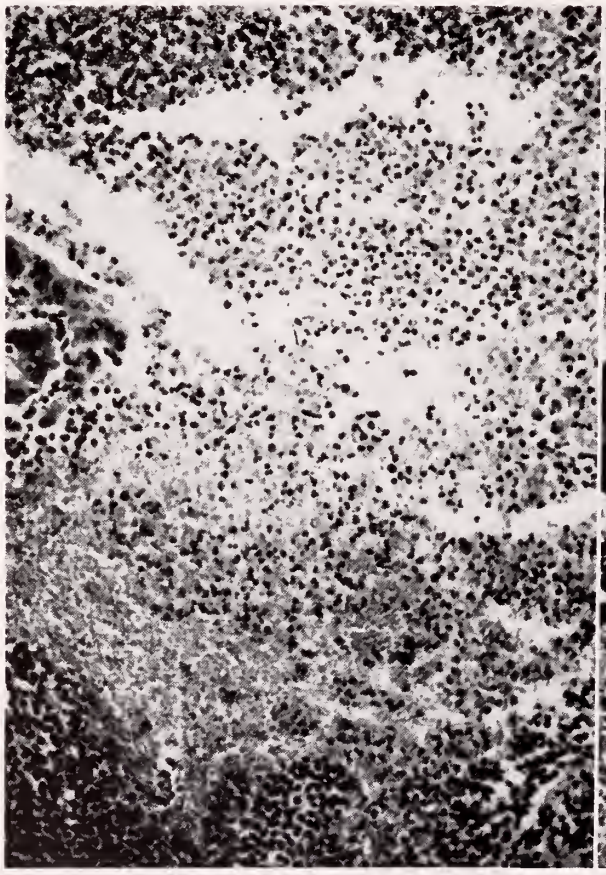

Figure 1. (x125) Lumen (upper half) filled with exudate. Mucosal breakthrough is shown in the center and an intact area of mucosa is seen on the left.

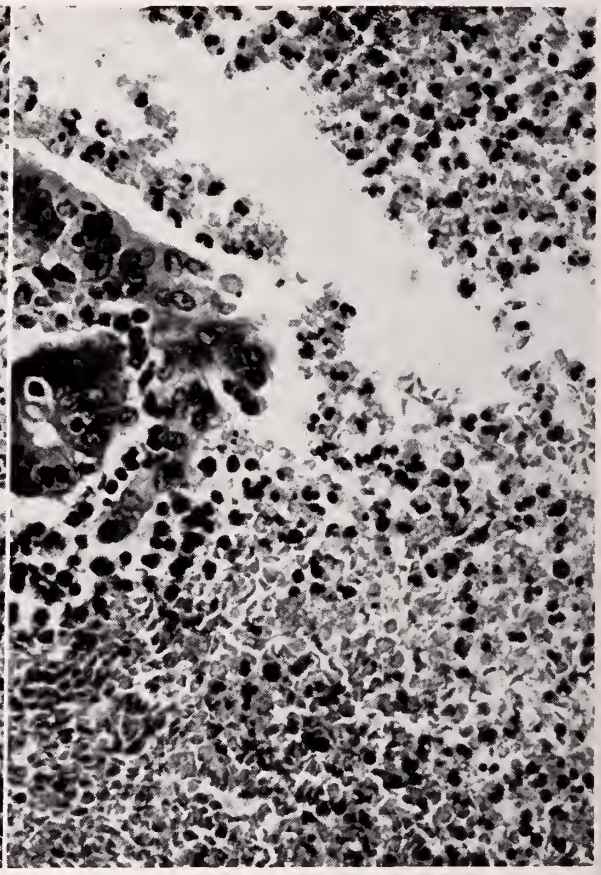

Figure 2. (x250)—Higher magnification of Figure 1, showing essentially similar histologic features.

called catarrhal) appendicitis" were utilized, i.e., presence of varying amount of neutrophilic purulent, or fibrinopurulent, exudate in the appendiceal lumen, or in the mucosal gland crypts with or without associated focus or foci of mucosal ulceration (See microphotographs). In this regard, it is to be realized that there still exists quite a bit of confusion among pathologists as to what actually constitutes the "typical" histologic picture of early acute, focal appendicitis.[1,2,3,4,6,7,8,11]

In none of the positive cases, among the incidental appendices, was any exudate observed in the appendiceal wall with one exception (Case 32), where eosinophilic abscesses of undetermined etiology were discovered. The purulent exudate in the appendiceal lumen was not graded as has been done by Schenken and co-workers.[11] Utilizing their criteria, however, their "Grade I, Acute Focal appendicitis" was not included in the present study which essentially consists of Grade III or Grade IV type of acute focal appendicitis with a few cases falling in Grade II category of Schenken and co-workers. If Grade I cases were included, there would be a high percentage yield of positive cases in this study.

No serial sections to demonstrate the presence of mucosal ulcerations or microabscesses of the lymphoid follicles of the mucosa were made. Cases with lymphoid tissue hyperplasia of the appendix, oxyuris vermicularis infestation without purulent exudate and iatrogenic or traumatic appendicitis were excluded from this study.

Discussion and Comment

The percentage of incidental appendices showing "incidental acute focal appendicitis" in this series is 10.03 and is not only significant but also well compares with other percentages of similar nature (12 per cent of Rossett and Conston, 2 per cent of Shelley and probably others). This observation, almost surely noted by many pathologists sporadically, is quite significant and tends to confirm the possibility of the existence, without clinical features, of a stage of acute appendicitis that either heals up or does not cause symptomatic discomfort to the patient, or possibly goes unrecognized on to the stage of "chronic obliterative appendicitis." At the same time, one begins to wonder if we are wrong in our concepts and histologic interpretation of acute focal appendicitis. It is also possible to postulate that perhaps the "acute focal appen-

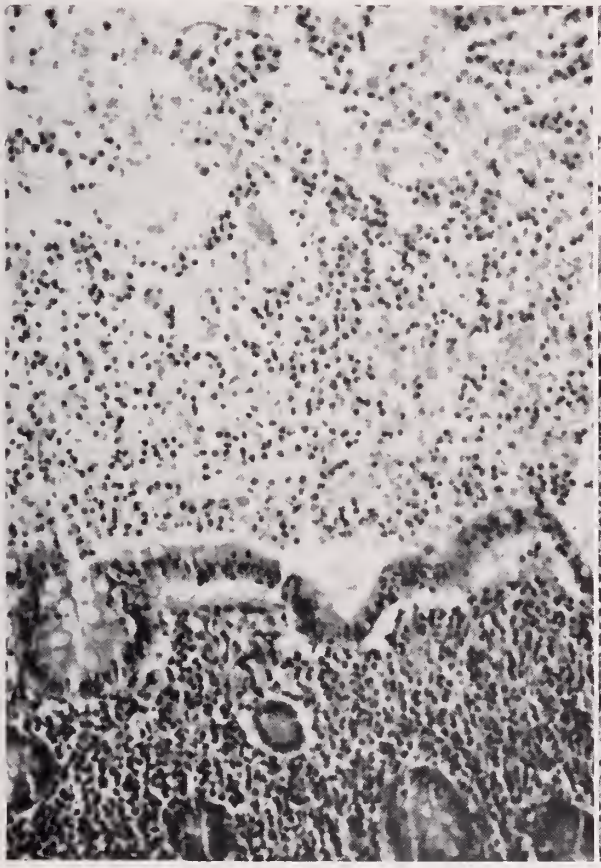

Figure 3. (x125)—Appendiceal lumen occupies upper two-thirds and is filled with exudate. Mucosa is intact.

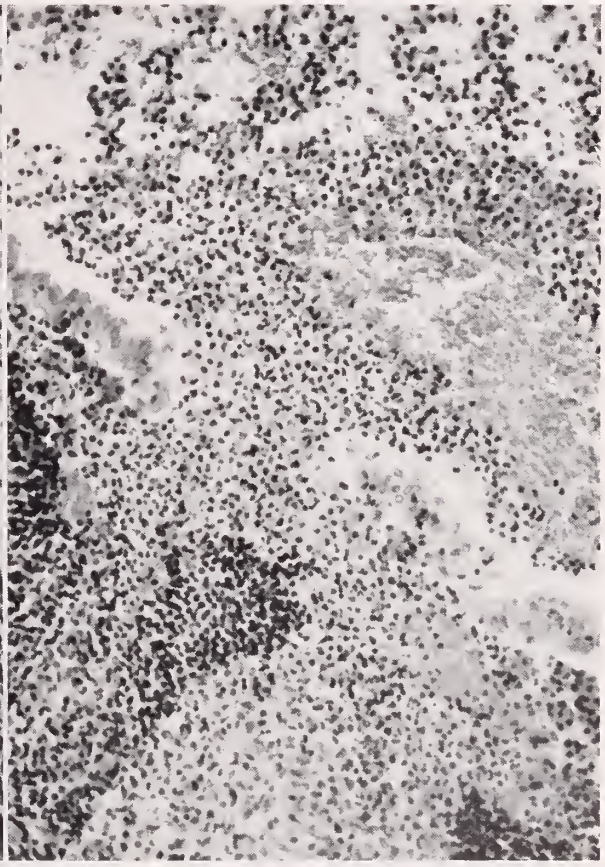

Figure 4. (x125)—Lumen of appendix (upper half) contains purulent exudate. A focus of mucosal ulceration is well shown in the center.

dicitis" is the product and manifestation of surgical maneuvering at the operating table and that maybe we should revise our histologic criteria of traumatic (iatrogenic) appendicitis. The histologic findings in these incidental appendices, it is felt, cannot be ignored completely and uniformity of opinion regarding their true nature is needed. Several hypothetical and practical problems can thus be brought up and listed as follows:

1. What is the exact basis and interpretation of these findings? Would it be logical to postulate that these patients "might have" gone on to full fledged clinical acute appendicitis were not, by a mere stroke of luck, the appendices removed "in time" incidental to some quite different surgical procedure?

2. Why do some but not all of the incidental appendices exhibit these histologic abnormalities? Does it mean that it differs with the type of surgeon or surgery performed?

3. Does it mean that our present concept of so-called iatrogenic (traumatic) appendicitis is erroneous? If so, should we include the occasional finding of exudate in the appendiceal lumen with or without associated mucosal ulceration, in the already existing histologic picture of traumatic appendicitis?[2]

4. Should every appendix that is accessible at the time of surgery be removed without fail during any surgical abdominal procedure, as also favored by others?[7,14,15]

5. Does the appendix in some way act as a sympathizer to its local and distant neighbors that cry out with "itis" or "osis", i.e., gallbladder, gastrointestinal tract, kidneys and pelvic viscera, bringing on a chain of events leading to activation of the surgeon's knife that at the same time removes the sympathizer as well?

6. Does this observation throw any light on any possible physiologic function of the vermiform appendix, including any probable role of the appendicocecal sphincter, since this observer has also seen a few sporadically removed appendices at post mortem show "acute focal appendicitis?"

Table 1
Organs Removed at Surgery (with Appendix)

1.	GALLBLADDERS	156
2.	UTERI	134
3.	OVARIES AND/OR TUBES	61
4.	FALLOPIAN TUBES	15
5.	GASTRECTOMIES	23
6.	VAGI	53
7.	INTESTINE	26
8.	LAPAROTOMIES	20
9.	HERNIAS	10
10.	MECKEL'S DIVERTICULA	5
11.	MISCELLANEOUS	25
	TOTAL	528

Table 2
Miscellaneous

1.	C. Sections	5
2.	Cystectomies	3
3.	Liver Biopsies	4
4.	Int. Obstruction	2
5.	Spleens	2
6.	Kidneys	2
7.	Umbilicus	1
8.	Lumbar Symp. Chain	1
9.	Stomach & Gallbladder	2
10.	Aorta	2
11.	Esophagus	1
	Total	25

Table 3
Cases with "Incidental Acute Focal Appendicitis"

1.	Gallbladders	17
2.	Uteri	15
3.	Ovaries	9
4.	Vagi (For Hiatus Hernia Repair)	3
5.	Laparotomies	3
6.	Kidney	1
7.	Urinary bladder	1
8.	Femoral hernia (incarcerated)	1
9.	Meckel's	1
10.	Gastrectomy	2
	TOTAL	53

7. Should we revise or look for additional factors in the etiology and pathogenesis of so-called acute focal appendicitis?

8. Is our present-day purely histological interpretation of "acute focal appendicitis" in fact what it says, or is there anything called "acute focal appendicitis" that has any clinical or pathologic significance? Are these the cases that go on to the so-called "chronic obliterative appendicitis?"

9. What is the real source of the purulent material found in the appendiceal lumen and why chiefly in the distal third of the organ? Does it really come from a "mucosal ulcer" that can be occasionally demonstrated, as suggested by some, or is it that the exudate perhaps comes in a passive manner from the cecum which happens to contain some exudate at the time of surgery?

10. Does the anatomic location and positioning of the appendix have any influence or significance on this observation?

11. Above all, how should such an observation be recorded in the pathology report? What possible reaction should one anticipate from the Tissue Committee proceedings in this regard?

Summary

Of 528 incidental, vermiform appendices removed, 53 showed histologic changes of early acute focal appendicitis. This is considered a significant and intriguing observation. Several hypothetical and practical problems are brought up and the whole subject thrown open to pathologists for further evaluation.

A list of references may be obtained by writing to The Journal.

Observations on the Physiological and the Psychiatric Aspects of Selected Types of Head Injury*

Charles E. Goshen, M. D.

Foreword

THE following is a report on somewhat different aspects of the general subject of head injury which might be of common interest to psychiatrist, GP, neurologist and neurosurgeon alike. Two sections of the report deal with studies made by the author himself on: (1) early signs of brain damage in boxers and (2) neurotic characteristics of postconcussional cases. The entire report purports to offer new understanding of certain aspects of head injury.

Boxer's Encephalopathy ('Punch Drunk')

In professional boxing circles there long has been known a syndrome of apparent cerebral deterioration referred to as "punch drunk." Folklore surrounding the condition has described it as one in which a professional boxer undergoes a progressive decline in his boxing prowess accompanied by an euphoric type of unawareness of his deficiencies, dilapidation of personal habits and a tendency to respond to hallucinated signals.

Apparently the first medical investigation of the condition was reported by Martland,[1] in 1928, in England. His study of several boxers who fitted the commonplace concept of the punch drunk state was principally concerned with its neurological aspects. He reported that the earliest signs of the syndrome appeared to be a change from previous performance to an increasing degree of slowness and uncertainty of skilled movements. Next was noted an unsteadiness of gait, then a similar unsteadiness of arm movements. In some instances, the state progressed thereafter to obvious memory losses and dysarthria. Carroll[2] and Winterstein[3] reported similar findings in 1936 and 1937, respectively.

Critchley,[1] in 1957, in England, published a rather comprehensive report which surveyed previous studies and added his own study of 69 cases. He concluded that serious head injuries in boxers are more common than is generally assumed and that the minor ones are more significant than is usually suspected. His article in the *British Medical Journal* is accompanied by a companion article by a medical examiner of the British Boxing Commission which attempts to minimize the harmful effects of boxing. Critchley reports, for example, that by 1956 there were 200 deaths reported among boxers in England, mostly due to subdural hematomas and lacerated brains. He attributes the punch drunk state to repeated knock-out blows to the chin. Sherrington, as early as 1906, offered a description of the knock-out which has become a classic: "The knock-out blow to the chin conveys concussion to the otocyst, reducing in a moment a vigorous athlete to an unstrung bulk of flesh whose weight alone determines its attitude." Critchley describes the event less dramatically: "A state of motor hypotonus and helplessness with a severe short-lived disturbance of consciousness." He further observed that the fall to the floor which ensues is highly likely to result in a second head injury when the head strikes the hard surface.

The punch drunk state is often progressive, going on to more and more serious states of disability. The progressive course is usually accompanied by, and undoubtedly related to, the fact that the boxer continues to sustain repeated knock-out blows, often, in fact, with increasing frequency. In some instances where progression continues in spite of the boxer giving up his traumatic occupation, there is likely to be found the complication of alcoholism which could easily be a new agent responsible for further brain damage.

The condition is most common in the second and third rate professional fighters who end up in traveling carnivals where they fight all comers regardless of weight, or as sparring partners for other boxers (in which case they become known

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to the trade as "punch bags"). The condition is rarely seen in Negroes.

The first sign of the condition is usually noticed by referees and coaches who observe that the boxer is becoming less and less alert to the maneuvers of his opponent, thus leaving himself open to blows to the head. In other words, impairment of attention and of vigilance is the earliest sign of brain damage. This state progresses to slowness of foot, then of arm movements, a complication which is unusually likely to leave the boxer susceptible to additional head injuries. A fatuous, euphoric attitude alternating with irritability sets in, with a conspicuous unawareness of the increasing impairment of judgment and the deterioration in defensive skill, a set of factors which serves further to advance the vicious cycle. Finally, diffuse neuromuscular phenomena often resembling multiple sclerosis or Parkinsonism with increasing memory impairment becomes thoroughly disabling. Headaches are frequently complained of during the progression but convulsions are rare. Autopsy shows diffuse, general atrophy of the cerebral cortex, sometimes with meningeal scarring and adhesions.

In the early stages, when brain damage is first suspected, and the decision to continue or arrest a boxing career becomes critical, diagnostic evaluation is much more difficult than it is later on when the signs are more prominent. Several investigators have been interested in finding reliable signs of early damage. Many varying reports of EEG findings lead to the inescapable conclusion that this test is not a reliable one. Pneumoencephalography has been reported to show an increase in subdural air, but this finding, too, is likely to be of little help in the doubtful cases. In short, no reliable test of early damage has been developed, except for the reports on impaired performance in the ring.

A heretofore unreported study in which the author participated was made several years ago and it, too, attempted to ascertain reliable indices of early post-traumatic brain damage in a group of boxers. The reason for choosing this particular group of subjects was dictated by an interesting fact revealed in the conclusions. The group of subjects was studied by means of electroencephalography, air studies, neurological examinations, extensive psychological tests and psychiatric interviews. None of the subjects was an advanced and obvious example of the punch drunk syndrome. All, as a matter of fact, had qualified for enlistment in the armed services. Most of them had been complaining of headaches, a few had observed a slowing down of their boxing maneuvering (which could have been attributed to age and poor training) and some showed rather extensive neurotic behavior, in which fear of getting hurt seemed dominant. A few others had no complaints and had noted no impairment of boxing skill. About one-fourth had already given up their boxing careers, and the remainder were currently engaging in relatively nontraumatic exhibition bouts.

At first, it seemed that the EEG's on these subjects constituted a reliable way of distinguishing those with from those without brain damage but as the study progressed the EEG proved increasingly unreliable. Air study next seemed to be the best index until second and third repeats were done on the same subjects with inconstant results, leading to abandonment of this as a valid index. Next, our faith was pinned on the results of psychological tests. The relatively poor performance of some subjects on these tests could be explained, however, on the grounds that those boxers with the most brain damage were also the poorest boxers, and had probably always performed worse than average on psychological tests. Faith in this index eventually waned. The next and final reliance was placed on the general, sometimes intuitive, impressions gained from psychiatric interviewing. It was found that the various boxers could be ranked according to variations in the level of alertness and attention observed during the interviews. Sometimes the impairment in this function was quite subtle and fleeting, but when observed often looked like little petite mal episodes, with transient dream states and brief loss of awareness of the line of questioning. It also seems apparent that some of the subjects had learned better than others how to cope with this impairment, thus serving to conceal it.

Another set of data showed a high degree of correlation with these findings in the field of alertness and attention, and tended to confirm our impression that the latter was a significant index. We found that either the boxer, his wife or his managers had almost always kept rather precise records of the number of times, and the length of time the boxer had been unconscious after having been knocked out. When the total number of minutes of unconsciousness were added up, the totals seemed to coincide with the degree of impairment of attention noted. The totals did not correlate, however, with the intensity of complaints or symptoms. The variations in these seemed, instead, to be a measure of the degree of neurotic overlay. It was our general conclusion that those boxers whose periods of unconsciousness were none or few in

number, and never over one minute at any one time showed little or no after-effects that could be attributed to brain damage. On the other hand, those who had suffered numerous knock-outs, and especially if unconsciousness lasted for more than one minute, were the ones who showed the most convincing signs of early brain damage.

We concluded, in short, that the extent of brain damage, presumably from any cause, is a function of and measurable by the length of time spent in the unconscious state. For professional and amateur boxers, it would appear, therefore, that accurate official accounts should be kept of unconscious time, and once a critical level (perhaps a total of less than five minutes in all, or more than a minute on any one occasion) should disqualify the subject from further boxing. Justification for the discontinuance lies in the high degree of probability that a small amount of brain damage can quickly lead to a greater amount because of the vicious cycle whereby decrease in vigilance and motor agility leads to increasing chances of sustaining further knock-out blows. It would be even more humane to outlaw the knock-out blow to the head altogether.

An analytic study of the head injuries seen in boxing suggests possible mechanisms. The classic blow to the chin must act to accelerate the victim's head in an angular motion with its center at the cervical-cranial junction, and at a very high velocity. The brain, within the calvarium, would lag behind the skull motion, thus pressing down on the inferior surface of the skull and falx and probably not too likely to injure it. At the junction of the brain stem with the spinal cord, however, a high degree of torque must be exerted as a result of the sudden rotational velocity. Presumably, this could reflexly bring about sudden paralysis of the cerebral circulation as well as paralysis of the pyramidal tracts. This in turn could lead to rather abrupt cerebral anoxia which could then produce the unconsciousness. Older theories assumed that the force of the knock-out blow primarily affected the vestibular apparatus, but this could account only for the hypotonus and not for the unconsciousness. The anoxia also accounts for the brain damage.

Certain laboratory evidence helps to confirm this view. Rossen[4] showed that in laboratory mammals sudden occlusion of the cerebral circulation resulted in loss of consciousness within only 6-7 seconds. Restoration of the circulation within 100 seconds (about 1½ minutes) resulted, then, in complete recovery. Irreversible coma resulted, however, if the occlusion lasted 5-6 minutes. Periods of occlusion falling between these two extremes (more than 1½, less than 5 minutes) produced varying and proportionate degrees of nonfatal brain damage. These times closely correspond with the data mentioned above in the study of boxers.

The adult human oxygen requirement of the brain is 50 cc's. per minute. The brain takes up about 20 per cent of the total body oxygen, even though it accounts for only two per cent of the body weight. Tolerance to anoxia seems to decrease with age. One-day-old rats, for instance, can survive about 50 minutes in a pure nitrogen atmosphere. At five days, they survive only 25 minutes, and at 15 days of age they die in five minutes. These figures closely parallel those for human infants. Cerebral oxygen requirements are remarkably stable. Even though all other body tissues vary widely in their minute-to-minute oxygen needs, very few factors alter cerebral oxygen requirements. Sleep, muscular activity and mental activity have no measurable effect. There seems to be no such thing, in other words, as an increased need for cerebral oxygen. Heavy doses, but not small doses, of barbiturates are accompanied by decreased oxygen consumption, and consequently such states carry the threat both of deep unconsciousness and permanent brain damage. The minimal ambient oxygen tension necessary for an alert brain is 10 per cent or 80 mm. of Hg. (50 per cent of the normal atmosphere). Actually, however, compensatory mechanisms of hyperventilation and increased heart rate keep the oxygen flow to the brain at the normal level. At atmospheric gas pressures of less than 10 per cent oxygen, these compensatory mechanisms begin to fail, so that normal oxygen supply declines, and impairment of consciousness results. At eight per cent atmospheric oxygen, the blood oxygen to the brain falls to 80 per cent saturation, which is low enough to produce marked changes in consciousness. When the cerebral circulation is occluded or in a state of reflex stasis, it takes only seconds for enough oxygen to be extracted from the blood to lower saturation to this critical level. If all the blood from the body is circulating but no new oxygen is being inhaled, the brain and other organs extract enough to lower the saturation to the critical level in about three minutes. No other tissue appears to be nearly so sensitive to anoxia as the brain.

When long or repeated periods of anoxia lead to brain damage, the neural cells which die appear to be scattered rather diffusely through

the upper parts of the brain, so that serious damage presents a pathological picture similar to multiple sclerosis. The reticular formation, or the connections of the reticular formation with the cortex, appear to be affected first, not, perhaps, because it is more vulnerable, but probably because impairment of its function is more sensitively manifest. Similarly, the mode of action of general anesthetics and sedative drugs seems to be very clearly that of producing an anoxic state in the reticular formation, thus impairing alertness and bringing about sleep.

Sublethal Closed Head Injuries (Postconcussion Syndrome)

Another related clinical problem is that of the type of head injury known commonly as "concussion," in which there is transient unconsciousness but without major signs of injury such as fractured skull, brain laceration or subdural hematoma. Although these cases generally represent relatively easy treatment problems at the time of injury, they are unusually prone to lead to protracted complaints and troublesome law suits, in which case they become known as "postconcussion syndrome."

The classical picture of the postconcussion syndrome is usually described as a person who has had a relatively minor head injury but for months or even years afterwards complains of headaches, giddiness and exhibits so-called "nervousness." These complaints are usually accompanied by many visits to physicians, a tendency to shop around among different physicians, and frequent elaborate diagnostic investigations. As such, they make for troublesome management problems in spite of the fact that the initial injury presents no great challenge in treatment, often, in fact, requiring very little treatment at all.

There are a number of reports in the literature of rather large series of head injury cases, including both the minor and the serious types. Russell,[5] in 1935, for instance, reported on 200 cases and his attention was particularly directed toward the period of unconsciousness. In 180 of his cases, the patient showed retrograde amnesia, sometimes going back only a few seconds prior to the injury, in other cases going back several minutes so that details of the accident were not remembered. Posttrauma amnesia was much longer in most cases, and was found to correspond with the period during which the patient appeared to be conscious but not yet fully oriented to his surroundings. In one case, this period was eight weeks. It appears, from this observation, that the alterations in consciousness following head injury and associated with subsequent amnesia are not solely states of unresponsive coma, but also should be seen as including those periods of apparent consciousness but with impairment in the level of awareness. The critical brain function involved, again, appears to be the reticular formation which allows for registration of information susceptible to later recall only when it is fully and normally operating, but which seems to be the most sensitive of all parts of the brain to disturbance in function.

Guttmann,[6] in 1943, reported 158 cases, directing his attention principally to the report of headache. He found that in 20 per cent of his cases the patient complained of headache after discharge from the hospital. He concluded that the longer after the injury a patient complained of headache, the more likely he was to present a neurotic picture. Two different types of headache are reported by different patients. One type is rather sharply localized at the site of the original injury, and is often accompanied by tenderness at this point. Penfield states these are probably due to meningeal adhesions at the site, but no one has confirmed this. The other type of headache observed is a more general throbbing or hammering discomfort, with occasional sharp jabs of pain, and invariably brought on by sudden head movements. These appear to be of a vasomotor type and flushing or sweating often accompanies them, lending support to this supposition. How this vasomotor instability might be related to the original injury is not apparent, except that there are a number of indicators which suggest the presence of some reflex arterial mechanism in the head which reacts to various insults to the cranium or its contents.

The giddiness often reported in the postconcussion patient is not true vertigo but seems related to the vascular headaches described, in that it is almost always brought on by sudden postural movements and accompanied by various vasomotor phenomena with a transient feeling of faintness. Friedman,[7] in 1945, reported on 200 cases in which 57 per cent of patients complained of this giddiness, and in each case it was related to postural change, and most prominent in those patients who had had the longest periods of amnesia following the accident. He also concluded, as Russell[5] did, that those patients who complained of the symptom for the longest periods of time after the injury were the ones most likely to appear neurotic.

The "nervousness" or "nervous instability" reported by the various follow-up studies was usually described as difficulty in concentration, easy fatiguability, and irritability. Although these various reports seem to imply that the post-head injury cases show an unusually high incidence of neurotic complications or overlay, the follow-up of post-back injury cases shows a very similar incidence, so that there is no particular reason for attributing the neurotic manifestations to the fact that the head itself was injured. Nevertheless, it would not be a surprise to find that neurotic people are more likely to be under the influence of alcohol or drugs which could make injury more likely.

The author studied a small number of these posttraumatic pictures and can offer a few rather speculative conclusions. In the first place, the cases studied had already gone through prolonged and intensive investigations on the part of more than two other physicians; there was always a problem of litigation involved and the patient had almost invariably been given conflicting interpretations by different examiners. Some of them demonstrated convincing evidence that they really did suffer from occasional periods of discomfort from headache and giddiness. When this was the case, they invariably presented the typical picture of the vasomotor instability precipitated by sudden postural changes. Nevertheless, in spite of this convincing evidence, the symptoms were not genuinely disabling to a great degree and were actually of rather brief duration. This series of cases, however, did overreact to the discomfort, made much more of it than it deserved, and universally used the transient discomfort, or the fear of its being repeated, as an excuse for avoiding responsibility. This phenomenon can be used as a reliable index of neurotic behavior. A simple and durable test for the presence of neurotic behavior in posttraumatic complaints, and one which can be easily employed by the surgeon or general practitioner, is the determination that the patient uses these complaints, valid or otherwise, as an excuse to avoid responsibility. It was also inferred above that some of the patients studied did not give the classical, convincing picture of the posttraumatic vasomotor headache. These, instead, presented a more typical neurotic picture with vague, poorly defined, inconsistent complaints with a conspicuous absence of dramatic and convincing expressions of simulated anguish in describing the nature of the symptom. Frequently, as a matter of fact, they acted insulted when a more precise description was asked for. In other words, all of the cases in the series could be legitimately labelled as neurotic, though two-thirds, at least, also demonstrated convincing though exaggerated evidence of genuine distress attributable to the head injury.

An interesting and revealing clue which offers further explanation of the post-head injury problem came to light during the above study. Quite accidentally, the author had occasion to study a few additional cases in which the patient had had similar head injuries in the past but were not currently complaining of any symptoms or disability and were not exhibiting conspicuous neurotic behavior. It was found that these two or three men had discovered that they could, when they wished, bring on the exact kind of vasomotor discomfort complained of by the other patients, and demonstrated this to the author. The differences between these cases and the other appeared to be, simply, that they had not only learned how they could bring on such symptoms, but they also had learned how to prevent them, by the same token. In other words, it seems reasonable to conclude that sensible and responsible people who have sustained the type of head injury which can lead to the development of the posttraumatic syndrome are very likely to adapt to the problem by learning how to avoid the discomfort (by avoiding sudden postural changes, for the most part), and as a result suffer no noticeable disability. Less sensible and less responsible people, on the other hand—those who characteristically do little to help themselves—do not make this adaptation but, instead, permit a relatively minor handicap to become an apparently major disability. Often it was suspected that the motivation for seeking a financial settlement was dependent as much on using this as concrete "proof" of disability as it was on getting the money itself.

Summary and Conclusions

The studies of closed head injuries outlined herein suggests a few theoretic and therapeutic conclusions which seem worthy of further exploration:

1. It is convincingly evident that the mechanism which leads to transient or permanent brain damage in the relatively minor closed head injury is anoxia. In the management of patients in the immediate postinjury period, therefore, it would seem evident that any procedure which increases or helps maintain the anoxic state would be detrimental. The use of sedatives and general anesthetics would, therefore, seem to be contraindicated, not only because they have an immediate and direct effect by suppressing respiration and circulation.

2. Short of overt, demonstrable neurological signs and laboratory evidence such as air studies, the most specific and durable sign of brain damage, when the latter is diffuse and largely cortical, is memory loss. Testing for memory loss is complicated by the tendency of many patients to learn how to adapt to the deficiency and conceal it. It seems safe to conclude, however, that any patient who has been unconscious following head injury beyond some critical period of time has almost certainly sustained some brain damage, and the extent of it is probably in direct proportion to the period of unconsciousness.

3. Although memory loss seems to be the most reliable evidence of brain damage, measurements of the loss are sometimes hampered by the way some people learn to adapt to it, and also by the frequent absence of a pre-injury baseline with which to compare current findings. People with low intellectual levels are especially difficult to assess. On the other hand, determination of impairments in the function of alertness and attention might prove to be the most feasible indicators. Development of standardized tests for this function is in order.

4. There seems to be a marked difference in the postinjury course of different patients who have sustained similar kinds of minor, closed head injuries, or "concussions," some appearing to recover without disability or distress, others going on to chronic periods of apparent disability. The latter group also tend to show neurotic manifestations. It may well be, as suggested in the study mentioned above, that the difference is mostly the result of differing ways of adapting to the same problem.

5. Neurotic behavior in the posttraumatic patient is a common and troublesome complication which has frequent legal overtones. A few rule-of-thumb principles apply to these cases, and can help simplify management problems. In the first place, the existence of significant degrees of neurotic overlay cannot be determined by, and is not particularly related to, the presence or absence of pathology. Neurotic behavior is, instead, an unrealistic or unreasonable way of handling a problem; the problem itself might be a genuine one. The use of symptoms referable to an injury for the purpose of avoiding responsibility is a reliable indicator of neurosis and, when symptoms are used for such a purpose, it is likely that they will appear exaggerated, that frequent complaints and many visits to doctors will follow and, above all, that the patient will be unlikely to learn how to make a comfortable adjustment to his problem.

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New Drugs But Old Problems

LSD and other psychedelic drugs to come suggest that some will be devised to have far reaching benefits upon perception, memory and mentation that may produce a new breed of man. We are probably on the threshold of "well-healed" scientific inquiry into mind-memory learning, problem solving, thinking. Attempts to understand the operations of the brain must produce knowledge whose impact upon our civilization may be immense. We must consider in advance how to deal with the ethical, political and social problems that may arise, if a real psychedelic drug comes into existence.—Louis H. Nahum, M. D., in Connecticut Medicine.

Oral Dexamethasone in Insect Bites

Abraham Tow, M. D.

INSECT bites, particularly those of the bee, wasp, yellow jacket and hornet, produce reactions varying from a simple swelling to a rare fatality. In an analysis[1] of 88 such fatalities, it was pointed out that "death is commonly ascribed to anaphylactic shock, but in the majority of cases diagnosis is based on nothing more than the fact that death ensued within a few minutes following an insect sting."

Treatment has consisted of drugs commonly employed for the relief of allergic reactions; the drugs include antihistamines and the corticosteroids. An opportunity to test the efficacy of an oral corticosteroid (dexamethasone) as the sole therapeutic measure presented itself during the past year.

The unusually dry weather encountered in Southern West Virginia during 1964 increased enormously the number of persons bitten by insects. Fifty patients were treated. Since many cases of dermatitis venenata were presenting themselves at the same time and since our results[2] with oral dexamethasone* alone had been uniformly successful, it was decided to use this drug. Both conditions are allergic phenomena.

In these bites there generally is prompt swelling at the site of the sting, especially if the nettle remains. If it does, it is best removed by flicking it out with a finger nail, starting a little below the injection site. An attempt to pull it straight out may result in leaving some of the noxious material and thus prolonging the reaction.

Generalized allergic phenomena may follow within a few moments or may be delayed until the next day. The reaction may be limited to swelling around the site of injection or it may be generalized, with urticarial wheals of varying sizes scattered over the body, edema of the lips, eyelids and ear auricles and swelling of various joints, especially the wrists, ankles and fingers. Itching may be truly distressing and the pain extremely intense because of the edema.

Results of Treatment

Results with oral dexamethasone were consistently successful. After trying various dosages, it was concluded that an initial dose of 6 mg. (8 tablets of 0.75 mg.) was most effective. Usually, 8 to 12 hours later, if required, 3 mg. were given and this dose repeated once or twice at the same intervals. This schema of dosage was followed regardless of age or size of the patient. The more severe the allergic reaction or the longer the delay in seeking treatment, the greater, in some cases, the amount of drug needed. In many cases, however, the initial dose of 6 mg. was sufficient to effect a cure. Nine case reports follow:

Case 1.—A four-year-old boy was seen at 10 P.M., two hours after he had been stung on the left upper eyelid. The nettle was still in the lid. It was flicked out from below. The eyeball was so edematous that it looked like a bowl of gelatine. The boy was given 6 mg. of dexamathasone orally. Within minutes improvement was apparent. By the next morning recovery was complete.

Case 2.—A 59-year-old male was seen one hour after he had been stung on the right temple, arm and leg. There was much swelling about the sites of injection. In the past, similar accidents had produced considerable generalized reaction. He was given 6 mg. of dexamethasone orally and the next morning all the swelling was gone. He had no further reactions.

Case 3.—A 17-year-old male was seen eight hours after having been bitten on the dorsal surface of the right hand. There was brawny swelling involving the hand and extending upward for one-third of the forearm. Six mg. of dexamethasone were given. Within 30 minutes there was a distinct decrease in the amount of swelling. Previously, he could not flex his fingers but now he could do so easily. Six hours later he was completely well.

Case 4.—A six-year-old male was stung on the left thumb. Within 15 minutes the thumb was badly swollen, red and tender. There was a

The Author

- **Abraham Tow, M.D., Guyan Valley Hospital, Logan, West Virginia.**

Submitted to the Publication Committee, September 1, 1965.

***Dexamethasone used by most of the patients was Hexadrol, supplied by Organon, Inc., West Orange, New Jersey.**

generalized rash over the trunk and extremities, with scattered wheals of varying size. Both auricles were red and the eyes were swollen. The itching was severe. He was given 6 mg. of dexamethasone and 15 minutes later there was visible improvement. The itching was gone. The next morning there was no evidence of these manifestations.

Case 5.—An 11-year-old female was stung on the anterior surface of the terminal phalanx of the right middle finger at approximately 8 P.M. on the night of June 29. Finger and hand became swollen, especially the palm and the dorsal surface of the finger. This became worse in the next 24 hours until she was unable to flex the finger. At 12:45 P.M. on July 1 she was given 6 mg. of dexamethasone. Within 30 minutes the edema had subsided to such an extent that she was able to bend the finger. By the following day she was fully recovered.

Case 6.—A 13-year-old male was stung several times by "yellow jackets," twice on the right arm, once on the left leg and once on the right heel. After only a few minutes his face was swollen, with both eyes and ear auricles involved. There was a large edematous area about the size of a golf ball on the right side of the neck. Urticarial wheals, varying in size from half a dime to a silver dollar, were scattered over face, trunk and extremities. He was seen within an hour of the accident and was given 6 mg. of dexamethasone. Two hours later the entire reaction had been dissipated.

Case 7.—An 18-month-old male infant had been stung on the nose by a wasp 36 hours previously. When seen, his left eye was completely closed due to edema of the lid. Both lids were involved. He was given 6 mg. of dexamethasone. The tablets were crushed and he was fed the sludge with a spoon. Twelve hours later the eye was open and the swelling of the lids had been reduced by over 50 per cent. Three mg. of dexamethasone were given twice, at 12-hour intervals, with complete recovery.

Case 8.—While eating a sandwich, a 36-year-old male was stung on the inside of the left cheek. This occurred at 11:30 A.M. By 1:45 P.M. the cheek was markedly swollen, with the edema involving the chin and part of the neck. The upper portion of the sternum was inflamed. He was given 6 mg. of dexamethasone at 2 P. M. and 3 mg. at 6 and again at 11 P.M. The severe itching was relieved by 10 P.M. The following day he received 1 tablet (0.75 mg.) twice, at 12-hour intervals. The next morning all was normal.

Case 9.—A two-year-old boy was stung on the penis. One hour later the foreskin was markedly edematous. It ballooned out and was translucent. He was seen two hours after this took place and was given 6 mg. of dexamethasone orally as a sludge. The next day he received 3 mg. This was repeated 12 hours later. The following day he was given 3 mg. at 8 A.M., with full recovery by afternoon of the same day.

It is important, in giving this medication orally, to make sure that all the tablets are swallowed. Some children may mouth the pills and then spit them out when not observed.

Conclusions

Oral dexamethasone is a reliable drug for the treatment of insect bites, particularly those of the bee, wasp, hornet and yellow jacket. An initial dose of 6 mg. is recommended, regardless of age or size of the patient. More medication is given as indicated.

No untoward reactions of any kind were observed in this series of cases.

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2. Tow, A.: Cortisone for Dermatitis Venenata, Pediat: 33:4, p. 617-8 (April) 1964.

He who hesitates is sometimes saved.

James Thurber

99TH ANNUAL MEETING

of the

West Virginia State Medical Association

The Greenbrier

AUGUST 25-27, 1966

Plan to Attend — Make Your Reservation . . . Now !

Pro-Banthine®
(propantheline bromide)

Intragastric photography has provided a new and precise method of measuring the effectiveness of anticholinergic drugs. The transition from gastric motor activity to relaxation seen with effective doses of such drugs takes only a few seconds and is easily demonstrated.

The importance of vagal stimulation of gastric hyperacidity and hypermotility makes such measurements particularly important in evaluating the parasympatholytic effect of drugs used in patients with peptic ulcer, gastritis, biliary dyskinesia and other gastrointestinal disorders.

Pro-Banthīne has been shown[1] to produce complete gastric motor inactivity with doses of 6 to 8 mg. intravenously. Comparison tests were made with the belladonna fraction, atropine. Measured usual dosage unit versus usual dosage unit, Pro-Banthīne was more than four times as effective as the belladonna alkaloid.

Indications: Peptic ulcer, functional hypermotility, irritable colon, pylorospasm and biliary dyskinesia.

Oral Dosage: Adequate dosage should be given for optimal results. For most *adult* patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthīne (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

Side Effects and Contraindications: Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. Pro-Banthīne is contraindicated in patients with glaucoma, severe cardiac disease and prostatic hypertrophy.

1. Barowsky, H.; Greene, L., and Paulo, D.: Cinegastroscopic Observations on the Effect of Anticholinergic and Related Drugs on Gastric and Pyloric Motor Activity, Amer. J. Dig. Dis. *10*:506-513 (June) 1965.

See fo

Is Effective

Complete gastric relaxation with Pro-Banthine. As this intragastric photograph demonstrates, gastric relaxation is attained with 6 mg. of Pro-Banthine intravenously; the antrum is relaxed and the pyloric orifice remains open. Full intravenous doses of atropine (4 mg.) produce no measurable effect.

SEARLE

Research in the Service of Medicine

A message from . . .

The President

DOCTORS DIVIDE AND CONQUER

USING an old warlike axiom may seem totally inappropriate to signify the challenge to our physicians in their campaign against one of our greatest problems in West Virginia—the critical doctor shortage.

By conquering, I signify our need to win by overcoming obstacles or opposition. By dividing, I mean the division or work and responsibility to make our professonal work more productive.

In the Governor's Task Force on Health, various forecasts have indicated that if our population trend is to be reversed from its present level of 1,750,000, we can expect in the next 20 years a population of 2,500,000. This is positive thinking, not the old defeatist attitude we have heard for so many years. If this forecast is to come about, we will need to increase our health workers from their present level of 20,000 to 60,000. The challenge is there to triple our force in just two decades.

My approach is "What can we do now?" One approach is to make our health team more efficient and effective. We must find new ways to work together, conserving our professional time through the further utilization of ancillary medical personnel and modern equipment.

Partnerships, groups and clinics are one approach, and they must consider ways and means of how they can become more effective to render a greater amount of quality care to a greater number of patients. Hospitals, extended care units and nursing homes must seriously consider how they can conserve and better utilize the valuable time of their professional staffs.

But the main problem is, and will continue to be, how the solo physician can better protect himself and still render greater service. A few hours of serious planning often can bring about an analysis of your work schedule that will save you many valuable hours.

The needs are apparent. We need 900 new physicians in West Virginia now to bring us up to the national ratio of one doctor for each 700 of population. And if you have the courage to plan for the future we will need 1,000 more by 1986. By simple arithmetic this figures out to approximately 100 new physicians per year, and this doesn't take into account the normal attrition due to deaths and relocations.

The immediate answer is obvious, but perhaps not very acceptable. We must divide and delegate more work to ancillary health workers, in order that we can render greater service to greater numbers. We must assess our needs, develop working recommendations, and set out together to meet the health needs of West Virginia, now, and in the future.

Seigle W. Parks, M. D., President

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EDITORIALS

A QUESTION OF SEMANTICS

The Council of our Association is faced with many responsibilities, most of which are clearly defined both as to their import and with clear indications as to what will be a fair and just solution of the matter at hand. In a majority of decisions, Council's responsibilities are pointed both to the profession and to those we serve. Such an event transpired at a recent Council meeting when the members were handed a copy of Resolution No. 62 of the Appalachian Regional Commission for the adoption of guidelines and criteria for the implementation of projects authorized by the Appalachian Regional Development Act of 1965.

The Appalachian Commission, consisting of the 12 governors of the Appalachian states, had reportedly adopted verbatim as a policy the recommendations of its Health Advisory Committee, a body numbering 25, one appointee by each of the 12 governors, and 12 federal appointees with Dr. Paul A. Miller, President of West Virginia University, as Chairman. Only one member was engaged in the private practice of medicine, yet this Committee was concerned with health matters which would require the advice and cooperation of medical men in all areas of Appalachia. In passing, it might be mentioned as a matter of questionable pride to all Mountaineers that West Virginia is the only one of 12 states in Appalachia in which *every* county is in effect classed as poverty-stricken. Not even the proud poor folks from Georgia, Alabama or Kentucky can match this distinction.

To get back in sequence, the very first paragraph of Section I, Project Criteria, stated that "each health facility project should have as its objective the phased development of comprehensive health services for all segments of the population in a designated area." Comprehensive health services are defined as "health education, personal preventive services, *diagnostic* and *therapeutic* services, rehabilitative and restorative services and community environmental health services." That adds up to nearly complete health care for all citizens at federal and public expense.

The Council took immediate action to (1) suggest to the Appalachian Commission that such a precept would not only invade, but could in time destroy the private practice of medicine, and (2) request the appointment of several private practitioners to the Advisory Committee.

Representatives of Council met with, and were told by members of the Advisory Committee that, despite the possible results from implementation of these projects, there was no intention on the part of the Commission to interfere with private medical practice, but rather, the

help of every physician was required and requested to produce a successful community health program. It was suggested that only a question of semantics was involved, but experience has shown that when a protest is not forthcoming at the very start of a project, there is less chance of altering harmful conditions after the project is in full swing.

Two weeks later a communication was received from Washington with a statement intended to clarify the Advisory Committee's intentions but the bold statement of "comprehensive health services for all segments of the population" still remains intact.

One cannot question the sincerity and devotion of these advisors for the long hours spent in formulating these guidelines, but this life is made up of realities which should be equitable to all concerned, if any degree of cooperation is reached. It is urged that the Appalachian Commission reconsider its action and accept the report prepared by our State Health Department for Governor Smith as of June 30, 1965. This proposed project is tailored and designed to meet the problems which exist in areas of West Virginia, and its adoption will go far in getting the approval and cooperation of organized medicine in West Virginia.

DR. DANIEL T. WATTS RESIGNS—ACCEPTS POSITION AT MCV

Dr. Daniel T. Watts, Chairman of the Department of Pharmacology of the WVU Medical Center, is resigning to accept a position as Dean of the School of Graduate Studies at the Medical College of Virginia in Richmond. Doctor Watts was born in Wadesboro, North Carolina. He received his B.S. degree from Elon College and his Ph.D. from Duke University. He served in the Navy, working in aviation physiology from 1942 to 1946, and worked at the Naval Air Experimental Station in Philadelphia in 1947. From 1947 to 1953, he taught in the department of pharmacology at the University of Virginia.

In 1953, Doctor Watts became chairman of the Department of Pharmacology at the West Virginia University School of Medicine. He is a nationally recognized pharmacologist and is consultant on drugs to the American Medical Association, a consultant in pharmacology for the Walter Reed Institute for Research and is a member of the National Institutes of Health training committee in pharmacology. Doctor Watts has built up a strong department at West Virginia University and his valuable services will be missed.

Doctor Watts was keenly interested in community affairs while in Morgantown. The following editorial from *The Morgantown Post* (February 3, 1966) pays high tribute to his services:

Our Town is Going to Miss Dan Watts

"It isn't only the University but also the community that is suffering a serious loss in the resignation of Dr. Daniel Watts to become dean of the graduate studies at the Medical College of Virginia in Richmond.

"As chairman of the Municipal Planning Commission, Dr. Watts has served with indefatigable devotion and unfailing good humor in what many would regard as one of the most thankless assignments of public service in town.

"Though problems of planning may seem little related to the medical science of pharmacology, Dr. Watts apparently has the idea that if he was going to be a resident of Morgantown he should do what he could to make it a good town —and he did just that in patiently sticking on the job of Planning Commission chairman.

"The University Medical Center will undoubtedly miss Dr. Watts, but the town may miss him even more. In any event we should like him to take with him to Richmond an assurance that Morgantown will not soon forget his service and his spirit."

FEDERAL GRANTS FOR UNDERGRADUATE AND RESEARCH TRAINING

There has been a steady increase in the amount of money allocated by the National Institutes of Health for undergraduate and research training grants. In 1958, the amount allocated to undergraduate training was $6.2 million and for research training $12.9 million, a total of $19.1 million. In 1960, the figures were respectively 6.6 and 30.2, a total of $36.8 million. In 1965, the estimated figures are respectively 8.9 and 85.0, a total of 93.9 million. This shows a prodigious growth within a period of a few years. It will be of interest to see whether the total will continue to rise and what the limit will be.

Grants for undergraduate training have to do with instruction in cardiovascular diseases, oncology and psychiatry. Grants for research train-

ing are concerned with stipends for predoctoral and postdoctoral fellows involved in training for teaching and research.

It will be noted that far more money is allocated for research training grants than for undergraduate training. The former grants make it possible for many students to learn research methods, which will enable them later to make contributions to the scientific literature. The training afforded by these grants also prepares students to teach in the biologic sciences in the broadest sense, that is, including clinical subjects. Presently more teachers are needed due to increased enrollments of medical students and to the building of more medical schools.

There is no doubt but these grants made by the National Institutes of Health presently provide an extremely important source of financial support for programs conducted by medical schools in the United States. If for some reason this support were withdrawn, many medical schools would find it difficult to continue their programs.

Criticism has been made that some of the students supported by research training grants are not especially interested in research or in teaching, but accept these grants for financial reasons. It can be said, of course, that these students, even though they are not interested in creative work, and may not teach or pursue research in later life, nevertheless have learned research methods, the value of the use of statistics and the development of a critical attitude toward biologic science in general. This is all quite worthwhile, but it is not enough. Those who are responsible for selecting students for this program should use every possible care to invite only those students who are genuinely interested in research, and who have, in a measure at least, a sympathetic attitude toward teaching.

There has been considerable criticism, furthermore, about the allocations of the graduate research training grants, and it has been alleged that certain schools in specified regions of the country obtain the lion's share. If this is true, a careful study should be made so that these huge funds may be more equitably allocated. Admittedly this is not easy to do, but ways and means should be found to distribute these funds more on a geographic basis. It is recognized that some schools are better equipped to use these funds, but there are many institutions which are deserving of more substantial grants.

BOLTS AND JOLTS

The Harris Act, controlling the use of barbiturates and amphetamines, is now the law of the land and investigators are looking for physicians and druggists who may be involved in sloppy drug keeping or may be unlawfully trafficking in these drugs for illegal revenue. The law was originally drawn to restrict the use of sleeping pills and certain stimulants to proper medical usage but has now been extended to cover a number of tranquilizers, sedatives, anorexics and whatever the FDA chooses to restrict at the moment.

Very few physicians dispense drugs except samples and the latter are given without charge and in the original packet. It now seems probable that there will be a drastic reduction in the distribution of samples. This restriction may be a voluntary action of the drug company or the government may issue another edict.

The dispensing physician will require some simple but adequate accounting to indicate the distribution of drugs which are named in the law and dispensing of such drugs will have to be restricted in quantity.

For many physicians and pharmacists the law is just another headache. Prescriptions cannot be refilled more than five times or extended more than six months. Many patients have used some of the barbiturates for years. Other patients have used anorexic drugs for a long time on the original prescription. To ease the burden, extension or renewal of prescriptions may be made by phone.

Reports to the Medical Licensing Board are made regularly by Federal agents interested in the enforcement of the Harris Act and it is apparent that the methods of some dispensing physicians will require an abrupt change if they wish to avoid trouble.

There are always a few of our number who will use their professional license for income unrelated to the proper practice of medicine. For most of us this law will have no impact. It is hoped the many news articles will warn any recalcitrant members before the G-Men have checked their slipshod habits.

The Drug Without Side Effects

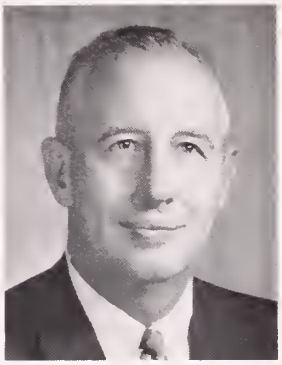
There exists an unrealistic public image of drugs that there could be remedial agents with various and optimum therapeutic effects without any toxicity. This is clearly utopian. The drug without side effects still remains to be discovered and it is most unlikely that it will ever be found.—Cornielle J. F. Heymans, M. D., in *Georgetown Medical Bulletin.*

GENERAL NEWS

Drs. Deyerle and Haserick To Speak At 99th Annual Meeting

Two prominent physicians have accepted invitations to appear as guest speakers at the 99th Annual Meeting of the West Virginia State Medical Association which will be held at The Greenbrier in White Sulphur Springs, August 25-27.

Dr. Carl B. Hall of Charleston, Chairman of the Program Committee, said that Dr. William M. Deyerle of Richmond, Virginia, and Dr. John R. Haserick of Cleveland have accepted invitations to present papers during the three-day meeting.



William M. Deyerle, M. D.

John R. Haserick, M. D.

Doctor Deyerle Native of Bluefield

Doctor Deyerle, who is Assistant Clinical Professor of Orthopedic Surgery at the Medical College of Virginia, will appear as a speaker at the second general scientific session on Friday morning, August 26.

Doctor Deyerle, a native of Bluefield, West Virginia, was graduated from Davidson College and received his M. D. degree in 1940 from the University of Virginia School of Medicine. He interned at the Medical College of South Carolina and served residencies at the Medical College of Virginia Hospitals and The Crippled Children's Hospital in Richmond.

During World War II he served for 31 months as a Captain in the Medical Corps of the United States Army.

Doctor Deyerle was certified by the American Board of Orthopedic Surgery in 1950, and he is a member of the American Academy of Orthopedic Surgeons, Association of Bone and Joint Surgeons and American Fracture Association. He serves as Associate Editor of *Clinical Orthopaedics and Related Research.*

John R. Haserick, M. D.

Dr. John R. Haserick, Professor and Director of the Department of Dermatology at The Cleveland Clinic Foundation, will appear as a speaker at the first general scientific session on Thursday morning, August 25.

A native of Minneapolis, Doctor Haserick attended Macalester College and the University of Minnesota. He received his M. D. degree in 1941 from the University of Minnesota School of Medicine.

He interned at Ancker Hospital in St. Paul, 1940-41, and served a Fellowship in Medicine at the University of Minnesota Hospital, 1941-42. He served as a Captain in the Medical Corps of the United States Army, 1942-46.

Doctor Haserick served as an Instructor in Dermatology at the University of Minnesota, 1947-48, and then joined the staff of The Cleveland Clinic Foundation. He has served as Head of the Department of Dermatology since 1957. He also serves as Associate Clinical Professor of Dermatology at Western Reserve University School of Medicine.

He was certified by the American Board of Dermatology in 1947. He is a member of the American Academy of Dermatology and a member of several other dermatological organizations. He is a Fellow of the American College of Physicians.

Doctor Haserick is a member of the Ohio State Medical Association and serves as a member of the AMA Committee on Cutaneous Health and Cosmetics and the AMA Residency Review Committee for Dermatology. He also is a member of the Speaker's Bureau of the Cleveland Academy of Medicine.

Drs. Hudson and Annis Honor Guests

The Program Committee announced previously that Dr. Charles L. Hudson had accepted an invitation to be the guest speaker before the first session of the House of Delegates on Wednesday afternoon, August 24, the day preceding the formal opening of the meeting.

Doctor Hudson will be installed as President of the AMA during the annual convention in Chicago later this month.

Another honor guest will be Dr. Edward R. Annis of Miami, Florida, a Past President of the American Medical Association, who will be the speaker at a WESPAC meeting on Thursday night, August 25.

Other physicians and surgeons who will appear as speakers are as follows: Dr. James T. Priestley, Head of a Section on Surgery at the Mayo Clinic and Pro-

fessor of Surgery at the Mayo Graduate School of Medicine, University of Minnesota; Dr. Robert I. Wise, Magee Professor of Medicine and Head of the Department at Jefferson Medical College; Dr. Robert B. Greenblatt, Professor and Chairman of the Department of Endocrinology at the Medical College of Georgia; and Dr. Doris A. Howell, Professor and Chairman of the Department of Pediatrics at the Woman's Medical College of Pennsylvania.

Governor Smith to Deliver Address

Gov. Hulett C. Smith has accepted an invitation to be among the honor guests and will appear as a guest speaker at the opening of the first general scientific session on Thursday morning, August 25.

Business Sessions Scheduled

There will be two sessions of the House of Delegates during the meeting. The first session will be held on Wednesday afternoon, August 25, the day preceding the formal opening of the convention. Doctor Hudson will be the speaker.

Dr. Seigle W. Parks of Charleston, President of the State Medical Association, will deliver his Presidential Address at the second session of the House of Delegates on Saturday afternoon, August 27.

The pre-convention meeting of the Council will be held on Wednesday morning, August 24.

Additional information concerning the program will appear in future issues of *The Journal*. The complete program will be published in the Convention Number in August.

AMA News Contest Winners Are Announced

The American Medical Association has announced winners in its $5,000 Medical Journalism Awards Contest.

First place winners in each of the five categories are:

Newspapers—Joann Rodgers and Louis Linley of the Baltimore News American for a series of articles on medicine and health.

Magazines—Ralph Lee Smith for an article in *The Reporter* entitled "The Vitamin Healers."

Editorial Writing—Jefferson D. Yohn of the San Bernadino (Calif.) Sun-Telegram for a series of editorials on progress in medical science.

Radio—WCBS, New York, for a program entitled "Under Whose Wing?"

Television—A tie. Sharing the award equally will be WMAL-TV, Washington, D. C., for a program entitled "Till We Meet Again," and the National Broadcasting Company, New York, for a program entitled "Who Shall Live?"

Each winner receives a cash award of $1,000 and a plaque for "an outstanding example of journalism that contributes to a better public understanding of medicine and health in the United States."

The AMA awards are for work published or presented in 1965. Entries are now being accepted for the 1966 contest.

Dr. Charles L. Hudson of Cleveland (left), President Elect of the American Medical Association, was guest speaker at the regular monthly meeting of the Kanawha Medical Society which was held at The Daniel Boone Hotel in Charleston on May 10. Doctor Hudson, who spoke on Medicare, is shown discussing medical affairs with (left to right): Dr. Seigle W. Parks, President of the West Virginia State Medical Association; Dr. John E. Lutz; Dr. George R. Callender, Jr., President of the Kanawha Medical Society; and Dr. Bert Bradford, Jr.

Spring Meeting of Council Held In Charleston on April 17

The Spring meeting of the Council was held at the Daniel Boone Hotel in Charleston on Sunday, April 17, 1966, with the Chairman, Dr. Albert C. Esposito of Huntington, presiding.

One of the principal items on the agenda was a discussion of the criteria and guidelines suggested by the Appalachian Regional Commission for projects under the Appalachian Regional Development Act of 1965. A report on the implementation of the Medicare Law in West Virginia was discussed and a report was received from the Committee on Medical Education and Hospitals concerning a study which had been undertaken to determine the advisability of establishing another two-year medical school in West Virginia.

Appalachian Regional Development Act

There was considerable discussion concerning Resolution No. 62 of the Appalachian Regional Commission pertaining to the criteria and guidelines for projects under Section 202 under the Appalachian Regional Development Act of 1965.

It was pointed out that the guidelines, which were established on March 25, contained certain provisions which were considered to be detrimental to the implementation of the Appalachian Regional Development Act.

The Council approved a resolution recommending that certain revisions be made in the guidelines and that the proposal originally submitted by health authorities in West Virginia be reconsidered.

Attending the meeting as guests were two members of the Health Advisory Committee to the Appalachian Regional Commission: Dr. Mildred Mitchell-Bateman, Director of the State Department of Mental Health; and Dr. N. Allen Dyer, Director of the Heart Disease Control Bureau of the State Department of Health.

Also attending the meeting and participating in the discussion were Dr. Daniel Hale of Princeton, Chairman of the Mercer County Board of Health; Mr. Gary Spencer, Coordinator of the West Virginia Appalachia Office; Mr. Jack Whiting, a Coordinator in the Governor's Economic Opportunity Agency; and Mr. Harry C. Wolfe, Executive Director of the Governor's Task Force on Health.

Medicare

There was considerable discussion concerning PL 89-97 (Medicare) which will go into effect on July 1.

The Council adopted a policy statement regarding government medical programs and directed that a copy of the statement be mailed to all members of the State Medical Association. The Council also approved a motion that members receive in the same mailing a copy of the resolution adopted in 1965 by the House of Delegates in regard to third-party medical programs.

Need For Additional Physicians

The Council received a report from Dr. Pat A. Tuckwiller of Charleston, Chairman of the Committee on Medical Education and Hospitals.

In his report, Doctor Tuckwiller stated that the Committee had been studying the state's physician shortage and the possibility of establishing a new two-year medical school.

He said that members of the Committee had decided that establishment of a second medical school was not possible at this time because of costs and it was their recommendation "that attention be directed instead toward expanding the present facilities of the West Virginia University School of Medicine so as to double its present enrollment and production of graduates within the next few years."

The texts of the resolutions adopted by the Committee and approved by the Council are as follows:

1. "That this Committee regards the establishment of another independent two-year medical school as unfeasible and that attention be directed instead toward expanding the present facilities of the West Virginia University School of Medicine so as to double its present enrollment and production of graduates within the next few years."
2. "That in order to render the highest standard of medical care to the people of West Virginia, the Committee advocates: (1) broadening the medical education of our medical students by the WVU Medical Center in cooperation with the State Medical Association by establishing supplemental instruction in the clinical years in other geographical areas in our state, (2) coordinating and improving graduate intern and resident programs, (3) providing increased postgraduate education for the practicing physicians of our State, and (4) rendering more attractive the practice opportunities for the new physicians in our State."

Proposed AMA Dues Increase

It was reported that the AMA Board of Trustees had recommended to the House of Delegates a $25-a-year increase in membership dues, effective January 1, 1967. The proposed increase to $70 a year will go before the House of Delegates for final action at the Annual Convention in Chicago later this month.

Following considerable discussion, the Council instructed the two West Virginia delegates to oppose the proposed dues increase.

Election of Honorary Member

The Council elected Dr. Charles E. Smith of Terra Alta to honorary life membership in the State Medical Association.

Report of the Medical Economics Committee

Dr. George R. Callender, Jr., Chairman of the Medical Economics Committee, appeared before the Council to present a report of several meetings conducted between members of the Association and various third-party Medical Programs. He said that a meeting had been held in March with representatives of the Nationwide Mutual Insurance Company, which was named to serve as intermediary for Part B, Title XVIII, of the Medicare Law in West Virginia.

Doctor Callender also reported that members of the Sub-committee on Federal Medical Activities met in

Charleston on April 16 with representatives of the Office for Dependents' Medical Care. He said that Brig. Gen. Norman E. Peatfield, Executive Director of ODMC, and Lt. Col. William H. Hayes, the Contracting Officer, traveled from Denver to Charleston to attend the meeting.

He pointed out that the 1966 ODMC contract had not been signed and that an extension of the 1965 contract to June 30 had been granted.

He reported that meetings also had been scheduled with the Compensation Commissioner and officials of the State Welfare Department, Veterans Administration and the Division of Vocational Rehabilitation.

The Council meeting was attended by Dr. Albert C. Esposito of Huntington, Chairman; Dr. Seigle W. Parks of Charleston, President; Dr. Kenneth G. MacDonald of Charleston, Treasurer; Dr. L. J. Pace of Princeton, Member of the Executive Committee; and Drs. Joseph L. Curry of Wheeling; G. Thomas Evans of Fairmont; Maynard P. Pride of Morgantown; Andrew J. Weaver of Clarksburg; R. L. Chamberlain of Buckhannon; I. Ewen Taylor of Huntington; A. J. Villani of Welch; Richard W. Corbitt of Parkersburg; William B. Rossman of Charleston; and Mr. William H. Lively, Secretary ex officio.

The meeting also was attended by Dr. C. A. Hoffman of Huntington and Dr. Frank J. Holroyd of Princeton, AMA Delegates; Dr. Thomas G. Reed of Charleston, AMA Alternate; Dr. James S. Klumpp of Huntington, Parliamentarian; Dr. N. H. Dyer of Charleston, Director of the State Department of Health; Dr. George R. Callender, Jr., of Charleston, Chairman of the Medical Economics Committee; Dr. N. Allen Dyer of Charleston, Director of the Heart Disease Control Bureau of the State Department of Health; Dr. Mildred Mitchell-Bateman of Charleston, Director of the State Department of Mental Health; Dr. Daniel Hale of Princeton, Chairman of the Mercer County Board of Health; Mr. Gary Spencer, Coordinator of the West Virginia Appalachia Office; Mr. Jack Whiting, a Coordinator in the Governor's Economic Opportunity Agency; and Mr. Harry C. Wolfe, Executive Director of the Governor's Task Force on Health.

Physical Medicine and Rehabilitation Meeting In San Francisco

The 44th Annual Session of the American Congress and American Academy of Physical Medicine and Rehabilitation will be held at the Sheraton-Palace Hotel in San Francisco, August 28 to September 2, 1966.

The Academy's program will feature a "Symposium on Strokes" and a "Symposium on Space Medicine and Technology and Physical Medicine and Rehabilitation: Common Interests and Problems."

The Congress will have a "Symposium on Management of the Disabled Patient" and a "Seminar on Bio-Medical Engineering Approaches to Problems of Human Disability."

Heart Publications Catalogue

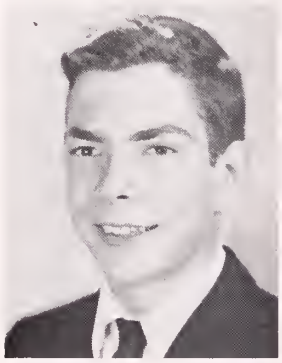
A new edition of *Scientific Journals and Books of the American Heart Association* has been issued.

A variety of publications on cardiovascular medicine are listed. Copies may be obtained by writing to the West Virginia Heart Association, 759 West Washington Street, Charleston 25302.

Officers of the West Virginia Chapter, American College of Surgeons, are shown during their annual meeting at The Greenbrier, April 14-16. Left to right: Dr. Richard A. Currie of Morgantown, Secretary-Treasurer; Dr. Harry F. Cooper of Beckley, Vice President; Dr. E. F. Heiskell, Jr., of Morgantown, retiring President; Dr. T. P. Mantz of Charleston, President; Dr. Charles M. Scott of Bluefield, Governor; and Dr. James H. Spencer of Chicago, Assistant Director of the ACS.

Two 1966 Scholarship Recipients Selected By Committee

James C. Bosley of New Creek, Mineral County, and Earl H. Eye, Jr., of Deer Run, Pendleton County, have been selected by the Medical Scholarships Committee of the West Virginia State Medical Association as the 1966 recipients of four-year scholarship awards to the West Virginia University School of Medicine.



James C. Bosley

Earl H. Eye, Jr.

Announcement of the awards was made by Dr. J. P. McMullen of Wellsburg, Chairman of the Committee.

The scholarships, each worth $4,000, are awarded annually by the State Medical Association to students accepted for the first-year class at the School of Medicine.

Bosley, 25, is the son of Mr. Thomas R. Bosley of Keyser and the late Mrs. Bosley. He is a graduate of Keyser High School and is married to the former Miss Linda Ruth Metcalf.

Eye, 21, is the son of Mr. and Mrs. Earl H. Eye of Deer Run. He attended Franklin High School.

Both men completed their pre-medical training at WVU, where they received A.B. degrees in May. They will begin their studies in September as freshmen in the WVU School of Medicine.

The Committee on Medical Scholarships of the West Virginia State Medical Association took time out for this picture while meeting in Morgantown, April 16-17. Front row (left to right): Dr. Martha J. Coyner of Harrisville; Dr. J. P. McMullen of Wellsburg, Chairman; and Dr. Russel Kessel of Charleston. Back row: Dr. Clark K. Slecth of Morgantown; Dr. John Mark Moore of Wheeling; and Dr. Thomas J. Holbrook of Huntington.

Bosley and Eye are the thirteenth and fourteenth students to receive scholarships under the program inaugurated by the State Medical Association in 1958. The Association awarded one scholarship per year until 1961, and the House of Delegates voted that year to provide an additional annual scholarship.

Rocky Mountain Cancer Conference In Denver, July 15-16

The 20th Annual Rocky Mountain Cancer Conference will be held in Denver, Colorado, July 15-16. The two-day meeting will feature some of the nation's most noted speakers on the subject of cancer.

Morning symposia will concern "Malignancies and Allied Diseases of the Chest" and "Diagnostic Methods and the Frequency of Their Utilization for all Forms of Cancer in the General Practice of Medicine and Surgery."

The first day's afternoon session will be devoted to presentation of papers by guest speakers. There will be an "Information Please" session on the afternoon of July 16.

Speakers on the scientific program will include: Dr. J. Max Chamberlain of New York, a thoracic surgeon; Dr. Emerson Day, Director of the Strang Prevention Clinic in New York; Dr. Robert C. Horn, Jr., Director of Pathology, Henry Ford Hospital in Detroit; and Dr. Leo G. Rigler, Department of Radiology, Center for Health Sciences, Los Angeles.

Drs. Charles L. Hudson, President Elect of the American Medical Association, and Leonard W. Larsen, President of the American Cancer Society, also will participate in the conference.

Additional information may be obtained by writing to Rocky Mountain Cancer Conference, 1809 East 18th Avenue, Denver, Colorado 80218.

Dr. W. B. Castle To Receive Goldberger Award

The Joseph Goldberger Award in Clinical Nutrition will be presented this month to Dr. William Bosworth Castle of Boston, who is internationally known for his investigations of nutritional and hemolytic anemias.

The award consists of $1,000 and a plaque and is presented annually by the American Medical Association's Council on Foods and Nutrition and the Nutrition Foundation, Inc.

Doctor Castle is receiving the award "in recognition of significant clinical and laboratory contributions to the understanding of pernicious anemia and other blood diseases." His scientific publications number more than 150.

Doctor Castle will receive the award June 29 at the Scientific Awards Dinner, which will be held during the AMA's Annual Meeting in Chicago.

Dr. Simmons Installed as President Of W. Va. Chapter, AAGP

Dr. L. Dale Simmons of Clarksburg was installed as President of the West Virginia Chapter of the American Academy of General Practice during the 14th Annual Scientific Assembly which was held at the Daniel Boone Hotel in Charleston, April 29-May 1.

He succeeds Dr. Jack Leckie of Huntington. Dr. Martha J. Coyner of Harrisville was named President Elect and will assume the presidency at the 1967 meeting, which will be held in Huntington, April 30-May 2.

Other new officers include: Dr. Del Roy Davis of Kingwood, Vice President; and Dr. C. Carl Tully of South Charleston, Secretary.

Drs. Seigle W. Parks and Carl B. Hall, both of Charleston, will be the Chapter's delegates to the AAGP meeting in Boston, October 11-14. Drs. James H. Wolverton of Piedmont and Frank M. Booth of Huntington were named to two-year terms as directors.

The Chapter approved a change in the by-laws to make the treasurer an elective office. Dr. James E. Spargo of Wheeling was elected to that office, but will not begin his duties until July 1. Until then, Doctor Tully will serve as Secretary-Treasurer.

The New President

A native of Grove City, Pennsylvania, Doctor Simmons holds a B.S. degree in pharmacy. He attended the old two-year School of Medicine at West Virginia University and received his M.D. degree in 1951 from the University of Maryland.

He is a member of the Harrison County Medical Society, the West Virginia State Medical Association and the American Medical Association.

During World War II, he served in the Medical Administrative Corps as a First Lieutenant. He was a Captain in the Medical Corps during the Korean War.

Dr. Richard E. Flood of Weirton (seated), President Elect of the West Virginia State Medical Association, confers with new officers of the West Virginia Chapter, American Academy of General Practice. Seated is Dr. Martha Jane Coyner of Harrisville, President Elect. Back Row: Dr. Del Roy Davis of Kingwood, Vice President; Dr. C. Carl Tully of South Charleston, Secretary; Dr. L. Dale Simmons of Clarksburg, President; and Dr. Jack Leckie of Huntington, Retiring President.

Guest Speakers

Fifteen prominent physicians and surgeons presented papers at the scientific sessions. Principal speaker at the annual banquet on Saturday night, April 30, was Dr. Stanley H. Martin, President of West Virginia Wesleyan College in Buckhannon.

AMA Medicare Booklet

The American Medical Association will publish a pamphlet on Medicare for use by physicians.

Dr. F. J. L. Blasingame, Executive Vice President of the AMA, announced that the booket would be published shortly after all regulations on Public Law 89-97 are published.

Mayor John Shanklin of Charleston (second from left) participated in the welcoming ceremonies for the meeting of the West Virginia Chapter of the American Academy of General Practice. With Mayor Shanklin are: Dr. Joseph A. Smith of Dunbar; Dr. Jack Leckie of Huntington, retiring President; and Dr. Peter A. Haley of Charleston. In right photo, Dr. Herbert N. Shanes of Grafton (right) is shown with two guest speakers, Dr. David B. Gray of Charleston (left), and Dr. Jack J. Rheingold of Washington, D. C. (center).

AMA Auxiliary Meeting In Chicago

The Woman's Auxiliary to the American Medical Association will hold its 43rd annual convention in Chicago, June 26-30, in conjunction with the AMA annual meeting. More than 2,000 doctors' wives are expected to attend the sessions at the Drake Hotel.

Mrs. Wilson P. Smith

Mrs. Wilson P. Smith of Huntington, President of the Woman's Auxiliary to the West Virginia State Medical Association, will head the West Virginia delegation in Chicago. Several other West Virginia Auxiliary members are expected to attend the meeting.

A highlight of the meeting will be a talk by Richard C. Cornuelle, author of *Reclaiming The American Dream*. He will speak at the Guest Day Luncheon on June 27.

Other events will include the June 26 reception honoring Mrs. Richard A. Sutter of St. Louis, President of the Auxiliary, and Mrs. Asher Yaguda of Newark, New Jersey, President Elect.

On June 28, national past presidents, AMA officers, trustees and their wives will be guests of honor at a luncheon at which Dr. James Z. Appel, AMA President, will be the speaker.

New officers will be elected on June 29, and Mrs. Yaguda will be installed as President the following day.

During convention business sessions, national chairmen will report on Auxiliary-sponsored community service programs in safety, rural health, disaster preparedness, mental health, health careers and international health activities.

All Auxiliary members, their guests and guests of physicians attending the AMA meeting may participate in the general sessions and social functions. The Auxiliary also will sponsor activities for physicians' children. Tours of Chicago landmarks, a baseball game and a barbecue are scheduled.

Mrs. Mitchell Spellberg of Chicago is in charge of local arrangements.

Auxiliary Board Meeting Held in Weirton

The Spring Board Meeting of the Woman's Auxiliary to the West Virginia State Medical Association was held at the Thomas E. Millsop Community Center in Weirton, April 26-27.

Members of the Woman's Auxiliary to the Hancock County Medical Society were hostesses.

Plans were discussed for the State Auxiliary's 43rd Annual Meeting at The Greenbrier in White Sulphur Springs, August 24-27. Guest speakers include Mrs. Asher Yaguda of Newark, New Jersey, President Elect of the Woman's Auxiliary to the American Medical Association; Dr. Seigle W. Parks of Charleston, President of the State Medical Association; Mrs. Anne Werstner Woods, nationally known author and arranger of flowers; and Mr. J. W. Swan of Washington, D. C., Secretary of the National Electrical Contractors Association.

Mr. Swan is the brother of Mrs. Wilson P. Smith of Huntington, President of the State Auxiliary.

Mrs. Smith presided at the Board meeting, during which annual reports were submitted by state officers and committee chairmen.

Dr. Richard E. Flood of Weirton, President Elect of the State Medical Association, addressed the group.

Another feature of the two-day session was a workshop for presidents elect of component auxiliary units. Mrs. Hu C. Myers of Philippi, President Elect of the State Auxiliary, conducted the workshop.

Several physicians accompanied their wives to the Auxiliary Board meeting. They were entertained at golf and a stag luncheon by Dr. Myer Bogarad of Weirton, a member of the Advisory Committee to the Auxiliary.

These officers of the Woman's Auxiliary were among members who attended the Spring Board Meeting in Weirton, April 26-27. Seated (left to right) are: Mrs. Rupert W. Powell of Fairmont, Fourth Vice President; Mrs. Wilson P. Smith of Huntington, President; Mrs. Hu C. Myers of Philippi, President Elect; and Mrs. Claude R. Davisson of Weston, Second Vice President. Standing: Mrs. D. E. Greeneltch of Wheeling, Parliamentarian; Mrs. Robert Greco of Morgantown, President Elect of the Monongalia County Auxiliary; Mrs. Charles E. Andrews of Morgantown, President of the Monongalia County Auxiliary; and Mrs. Edward A. Gretchen of Weirton, President of the Hancock County Auxiliary. At right is the Weirton Steel Company Male Chorus, which entertained at a banquet. (Photos courtesy of Weirton Steel Company).

New Association Members

Dr. John L. Fullmer, 596 Willey Street, Morgantown (Monongalia). Doctor Fullmer, a native of Masontown, was graduated from the WVU School of Pharmacy and received his M. D. degree in 1963 from the WVU School of Medicine. He interned at Marim County General Hospital in Indianapolis, Indiana, 1963-64. He served with the United States Air Force, 1952-56, and he is engaged in general practice.

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Dr. James F. Marshall, Greenbrier Valley Hospital, Ronceverte (Greenbrier Valley). Doctor Marshall, a native of Connellsville, Pennsylvania, was graduated from Washington and Jefferson College and received his M. D. degree in 1955 from Hahnemann Medical College. He interned at Hahnemann Medical College Hospital, 1955-56, and served a residency at Harrisburg General Hospital in Harrisburg, Pennsylvania, 1958-61. He was previously located in Berkeley Springs and his specialty is obstetrics and gynecology.

* * * *

Dr. John S. Palkot, 615 Winchester Avenue, Martinsburg (Eastern Panhandle). Doctor Palkot, a native of McKees Rocks, Pennsylvania, was graduated from the University of Pittsburgh and received his M. D. degree in 1964 from the West Virginia University School of Medicine. He interned at Lewis-Gale Hospital in Roanoke, Virginia, 1964-65. He served in the Middle East Theater during World War II and he is engaged in general practice.

* * * *

Dr. Thomas V. Shiels, Box 8004, South Charleston (Kanawha). Doctor Shiels, a native of Saskatchewan, Canada, was graduated from the University of Illinois and received his M. D. degree in 1939 from the University of Illinois School of Medicine. He interned at the Swedish Covenant Hospital in Chicago, 1939-40, and served a residency at the VA Hospital in Louisville. He was previously located in Williamson and his specialty is internal medicine.

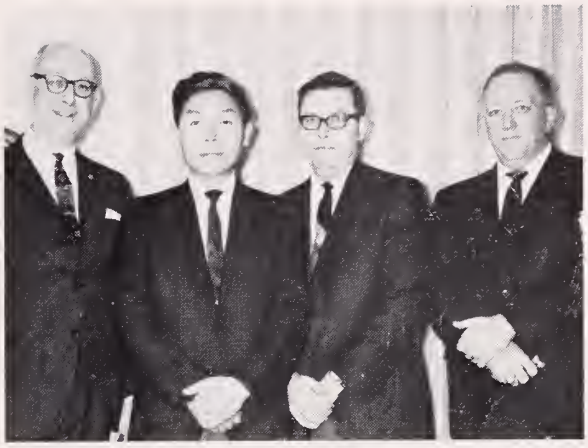
* * * *

Dr. Philip M. Sprinkle, WVU Medical Center, Morgantown (Monongalia). Doctor Sprinkle, a native of Greensboro, North Carolina, was graduated from the University of Virginia and received his M. D. degree in 1953 from the University of Virginia School of Medicine. He interned at Virginia Mason Hospital in Seattle, Washington, 1953-54, and served residencies at the University of Virginia Hospital and Watts Hospital in Durham, North Carolina. He has served with the United States Air Force and the United States Naval Reserve. He was located at the University of Virginia School of Medicine prior to accepting appointment as Chairman of the Division of Otolaryngology at the WVU School of Medicine.

Superintendent Resigns

Dr. Earnest Andia, Acting Superintendent of the state's Colin Anderson Center for Retarded Children in St. Marys, has resigned to continue medical studies.

The resignation was effective May 31. Dr. Mildred Bateman did not name a successor immediately.



Dr. Seigle W. Parks (left), President of the West Virginia State Medical Association, made his official visit to the Logan County Medical Society on April 13. Shown with Doctor Parks are: Dr. K. H. Lee (second from left), President of the Logan County Medical Society; Dr. Thomas P. Long, Vice President; and Dr. Mark S. Spurlock, Secretary.

New York Life Sponsors New Scholarship

The New York Life Insurance Company has established and financed a new scholarship to the WVU School of Medicine and 10 other medical schools in the United States and Canada.

Starting this fall, the program will provide one scholarship for a member of each new medical class who would otherwise have serious problems in entering a career in medicine.

The amount of each grant will depend on a budget to be worked out by Dr. Clark K. Sleeth, Dean of the School, with the scholarship recipient. Each scholarship will cover tuition, room, board, fees, books and equipment.

The School of Medicine will be solely responsible for selection of the recipient. The scholarship is to be awarded without regard to race, creed, color, national origin, sex or age.

Annual Rural Health Conference At Jackson's Mill, Oct. 6

The 19th Annual Rural Health Conference, which is sponsored by the West Virginia State Medical Association, will be held at Jackson's Mill on Thursday, October 6, 1966.

The program for the Conference is being arranged by the Chairman of the Rural Health Committee, Dr. Martha J. Coyner of Harrisville, in consultation with representatives of interested farm groups, the Cooperative Extension Service, and the State Department of Health.

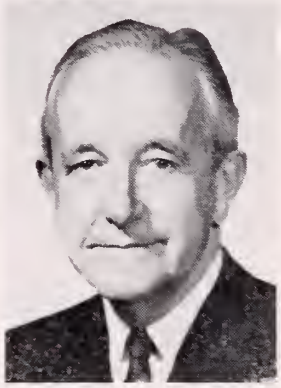
Further information concerning the program will appear in future issues of *The Journal*. The complete program will appear in the issue for September.

115th Annual AMA Meeting In Chicago, June 26-30

An attendance of 45,000, including 15,000 physicians, is expected for the 115th Annual Meeting of the American Medical Association in Chicago, June 26-30.

Dr. James Z. Appel of Lancaster, Pennsylvania, President of the AMA, will preside at the session. A highlight of the convention will be the installation of his successor, Dr. Charles L. Hudson of Cleveland, Ohio.

James Z. Appel, M. D.



Charles L. Hudson, M. D.

Scientific Program

A diverse scientific program covering virtually every specialty will be presented. The AMA's policy-making House of Delegates will meet at the Palmer House, and more than 350 scientific exhibits will be on display at the McCormick Place convention center.

McCormick Place also will be the site of many scientific sessions and an extensive medical motion picture and television program. The telecasts will originate from the University of Illinois College of Medicine, University Hospitals, Chicago.

House Meets on Sunday

The House of Delegates will convene at 3 P.M. on Sunday, June 26. The scientific program will open at 9 A.M. on Monday, June 27. Exhibits will be open at 10 A.M. Sunday and will be open Monday through Thursday from 8:30 A.M. to 5 P.M.

Topics of the six general scientific sessions include emphysema, population expansion, burns, mysterious fevers, community hospitals and coronary care units, and headaches. In addition to the general sessions, each of the 23 scientific sections will present scientific programs.

Many of the section programs will, as in past years, be joint meetings of two or more sections and, in some instances, a specialty society

The entire scientific program for the 1966 meeting was published in the May 9 issue of *The Journal of the American Medical Association.*

Drs. Frank J. Holroyd of Princeton and C. A. Hoffman of Huntington will represent the West Virginia State Medical Association in the AMA House of Delegates. Alternate delegates are Drs. Thomas G. Reed of Charleston and D. E. Greeneltch of Wheeling.

Astronauts Will Participate In ACCP Program

The 32nd Annual Meeting of the American College of Chest Physicians will be held in Chicago, June 23-27.

A panel discussion on "Cardiopulmonary Aspects of Space Travel" will be a highlight of the meeting. Dr. Charles A. Berry, Chief of Center Medical Programs, NASA Manned Spacecraft Center, will moderate the panel.

Panelists will include two astronauts, Air Force Col. Frank Borman and Navy Capt. James Lovell; Lt. Col. John Ord, Director of Crew Test and Evaluation, Headquarters AMD, Brooks Air Force Base, Texas; and Dr. Stuart Bondurant, Associate Professor of Medicine, Indiana University Medical Center in Indianapolis.

The panel discussion will be at 8:30 A.M., Saturday, June 25. The five-day meeting also will include other panel discussions, seminars, roundtable luncheon discussions, scientific motion pictures and formal papers.

State Physicians To Take Part In AMA Program

Dr. James H. Walker of Charleston will participate in the scientific program of the Section on Diseases of the Chest during the annual meeting of the American Medical Association in Chicago, June 26-30.

Doctor Walker will participate in a panel discussion of "Prevention and Management of Cardiac Arrest" at a roundtable luncheon at McCormick Place on June 27.

Several other West Virginia physicians will be connected with the AMA's scientific program. Dr. I. E. Buff of Charleston is a member of a committee that will direct screening examinations for physicians at McCormick Place, and Dr. Edmund B. Flink of Morgantown will be the Section of Internal Medicine's representative to the Scientific Exhibit.

An exhibit entitled "The Pathology of Coal Workers' Pneumoconiosis" will be shown by four Beckley physicians. They are: Drs. Warfield Garson, Werner A. Laqueur, Donald L. Rassmussen and H. A. Wells, Jr., Division of Occupational Health, Public Health Service.

AMA Headquarters Tour

All physicians, wives and guests attending the annual meeting of the American Medical Association in Chicago are invited on a guided tour of the AMA headquarters and the new Institute for Biomedical Research.

Tours will be conducted every hour from 9 A.M. to 4 P.M., Monday, June 27, through Friday, July 1.

Guides will escort the visitors and answer questions regarding AMA publications, services and activities.

State's Last Rabies Death Three Years Ago

In a recent issue of the "State of the State's Health," State Health Director N. H. Dyer reported that the last human death in West Virginia officially listed as caused by rabies occurred in 1963.

In 1965, West Virginia recorded 27 cases of rabies in animals and so far in 1966 the State Department of Health has 18 cases listed. Last year the Health Department recorded 1,267 cases of animal bites and so far this year the department has listed 244 cases. Doctor Dyer noted that each animal bite represents a potential case of human rabies.

Rabies, or hydrophobia, is a virus disease that occurs in all warm-blooded animals although it is most frequently encountered among the carnivores, the "meat eaters", because of their biting habits, Doctor Dyer explained. In West Virginia, the fox is the most frequently incriminated wild animal in the spread of the disease, while dogs are chiefly responsible for human exposures because of their close association with man. Doctor Dyer noted that stray dogs frequently roam through forests and streets carrying the disease from the wild animal reservoirs to the human and domesticated animal populations. Other chief spreaders of this disease are the skunk, cat, and bat.

"Rabies is transmitted in the saliva of an infected animal through a bite or a lick of an open cut or wound," Doctor Dyer said. "Rabies virus may be present in the saliva from eight to ten days before symptoms appear. It is well to be suspicious of any animal bite even though the animal appears healthy. Rabies can also be spread through the air, possibly by dried fecal material. The Communicable Disease Center has reported two deaths due to airborne human rabies infection."

It takes two to six weeks after contact for rabies to develop, Doctor Dyer noted, but it may develop in less than ten days or not for several months. Since the virus reaches the brain by way of the nerves, the closer the wound is to the brain, the more quickly the symptoms of rabies appear.

Even after the virus has entered the body, rabies can usually be prevented with the Pasteur treatment—a series of injections with antirabies vaccine, Doctor Dyer explained. This treatment prevents the disease in most cases if it is started soon enough and continued long enough.

Immediate reporting of suspected animals to the local health department is essential to accurate reporting which allows the respective authorities in the Department of Agriculture and the Department of Health to institute recognized rabies control measures once positive specimens confirm the existence of the disease, Doctor Dyer concluded.

W. Va. Acad. of Oph. & Otol. Installs Dr. McKinney

Dr. Worthy W. McKinney of Beckley was installed as President of the West Virginia Academy of Ophthalmology and Otolaryngology during the annual meeting at The Greenbrier in White Sulphur Springs, April 13-16.

Other new officers are: Dr. William C. Morgan of Charleston, President Elect; Dr. J. Elliott Blaydes, Jr., of Bluefield, Secretary-Treasurer; and Drs. Alfred J. Magee of Charleston, Edward Shupala of Parkersburg and Nime K. Joseph of Wheeling, Directors.

Eye, ear, nose and throat physicians from West Virginia and about 32 other states attended the 19th annual session. The next meeting will be held at The Greenbrier, April 23-26, 1967.

Drs. Saul Sugar of Detroit, William F. Hughes of Chicago and Jorge Buxton of New York City presented papers on ophthalmology. Speakers on otolaryngology were Drs. Charles Norris of Philadelphia, Manford McGee of Detroit and Philip Sprinkle of the WVU School of Medicine in Morgantown.

Dr. Ralph W. Ryan of Morgantown (left in left picture), Immediate Past President of the West Virginia Academy of Ophthalmology and Otolaryngology, is shown with new officers of the group during the spring session at The Greenbrier, April 13-16. Officers (left to right from Doctor Ryan) are: Dr. Worthy W. McKinney of Beckley, President; Dr. William C. Morgan, Jr., of Charleston, President Elect; Dr. Edward Shupala of Parkersburg, Director; and Dr. J. Elliott Blaydes, Jr., of Bluefield, Secretary-Treasurer. Guest speakers are shown in right photo. Left to right: Dr. Philip M. Sprinkle of Morgantown; Dr. T. Manford McGee of Detroit; Dr. Charles M. Norris of Philadelphia; Dr. William F. Hughes of Chicago; Dr. Jorge N. Buxton of New York City; and Dr. Saul Sugar of Detroit.

Dr. C. A. Hoffman Elected Secretary Of Blue Shield Board

Dr. C. A. Hoffman of Huntington was elected Secretary of the Board of Directors of the National Association of Blue Shield Plans during the Annual Business Meeting in Chicago, April 15-17.

Doctor Hoffman was elected to membership on the Board of Directors in 1965 and was named a member of the Executive Committee a few months later.

A Past President of the West Virginia State Medical Association, Doctor Hoffman serves as one of the two West Virginia delegates to the American Medical Association and also is a member of the AMA Council on Medical Service.

Richard M. Nixon To Speak At Chicago Meeting

Former Vice President Richard M. Nixon will be one of the featured speakers at the meeting of the Conference of Presidents and Other Officers of State Medical Societies in Chicago on June 26.

The meeting, beginning at 9:30 A.M., will be held at The Palmer House in conjunction with the Annual Meeting of the American Medical Association.

The other speaker will be Dr. Angus Murray, President of the Australian Medical Association. Doctor Murray will tell how Australian doctors defeated a government program to socialize fully the medical profession of that continent.

Dr. Walter C. Bornemier of Chicago is President of the Conference.

Health Professions Act Funds Available

U. S. Surgeon General William H. Stewart has announced that scholarship funds totaling $3,807,000 have been made available for fiscal year 1967 under the Health Professions Educational Assistance Amendments of 1965.

The funds will be administered by 227 schools of medicine, pharmacy, dentistry, optometry, osteopathy and podiatry.

Three schools in West Virginia, all part of the WVU Medical Center, are receiving funds. They are as follows: School of Medicine, $12,200; School of Dentistry, $11,200; and School of Pharmacy, $10,000.

The grants are to be used by the participating schools to assist students from low income families who could not obtain an education in a health profession without financial support. Scholarships will be available to full-time first-year students entering health professions schools next fall. A student may receive up to $2,500 for an academic year.

Administration of the scholarships, including the selection of the students and the amounts to be awarded to each, is the responsibility of the school.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1966

June 2-4—American Gyn. Soc., Hot Springs, Va.
June 17-18—Am. Rheumatism Assn., Denver.
June 20-22—Am. Proctologic Soc., Cleveland.
June 23-27—ACCP. Chicago.
June 24-25—Am. Geriatrics Soc., Chicago.
June 25-26—Am. Diabetes Assn., Chicago.
June 25—Am. Acad. of TB Phys., Chicago.
June 25—AMA Seminar on Medicare Regulations, Chicago.
June 26-30—AMA Annual Meeting, Chicago.
July 7-9—Am. Med. Women's Assn., Rochester, N. Y.
July 10-14—Med. Women's Int. Cong., Rochester, N. Y.
July 15-16—Rocky Mtn. Cancer Conf., Denver.
Aug. 25-27—W. Va. State Medical Assn., White Sulphur Springs.
Aug. 29-Sept. 1—Am. Hosp. Assn., Chicago.
Sept. 8-10—Am. Assn. of Ob.-Gyn., Hot Springs, Va.
Sept. 9—Maryland Medical, Ocean City.
Sept. 16-24—Am. Soc. of Clinical Path., Washington.
Sept. 17-23—Col. of Am. Pathologists, Chicago.
Sept. 20-22—Kentucky Medical, Louisville.
Sept. 23-24—W. Va. Heart Assn., Morgantown.
Sept. 23-Oct. 1—Am. Soc. of Clinical Pathologists, Chicago.
Sept. 30-Oct. 2—W. Va. Div., Am. Cancer Soc., Cacapon State Park.
Oct. 1-5—Am. Soc. of Anesthesiologists, Philadelphia.
Oct. 6—Rural Health Conf., Jackson's Mill.
Oct. 7-8—AMA Cong. on Medical Quackery, Chicago.
Oct. 10-13—AAGP, Boston.
Oct. 10-14—ACS, San Francisco.
Oct. 11-14—Pennsylvania Medical, Pittsburgh.
Oct. 15—Cabell County Symposium, Huntington.
Oct. 15-16—Am. Assn. of Oph., Chicago.
Oct. 16-21—Am. Acad. of Oph. & Otol., Chicago.
Oct. 21-25—Am. Heart Assn., New York.
Oct. 22-27—Am. Acad. of Pediatrics, Chicago.
Oct. 23-26—Am. Col. of Gastroenterology, Philadelphia.
Oct. 31-Nov. 4—Am. Assn. of Public Health Physicians, San Francisco.
Nov. 6-9—Med. Soc. of Virginia, Williamsburg.
Nov. 14-17—Southern Med. Assn., Washington.
Nov. 15-20—Am. Medical Womens Assn., Washington.
Nov. 26-27—Am. Col. of Chest Physicians, Las Vegas.
Nov. 27-30—AMA Clinical Convention, Las Vegas.
Dec. 2-3—Am. Rheumatism Assn., Cincinnati.
Dec. 3-6—Am. Acad. for Cerebral Palsy, New Orleans.
Dec. 3-8—Am. Acad. of Dermatology, Bal Harbour, Fla.
Dec. 6-8—Southern Surgical Assn., Boca Raton, Fla.

1967

Jan. 14-19—Am. Acad. of Orthopaedic Surgeons, San Francisco.
Jan. 28-Feb. 1—Am. Acad. of Allergy, Phoenix.
Feb. 14-19—Am. Col. of Cardiology, Washington.
March 10-11—AMA Conf. on Rural Health, Charlotte, N. C.
March 9-11—AMA-ABA National Medicolegal Symposium, Miami Beach.
March 19-24—Southeastern Surgical Cong., Bal Harbour, Fla.
April 7-9—Am. Soc. of Int. Med., San Francisco.
April 23-26—W. Va. Acad. of Oph. and Otol., White Sulphur Springs.
April 30-May 2—W. Va. Chapter, AAGP, Huntington.

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Intrauterine Contraceptive Devices*

D. Frank Kaltreider, M. D.

Many peoples throughout the world have accepted the two-century-old Malthusian proposition that population increase will result in unreasonable and unacceptable living conditions. The various methods of contraception that have been devised have been generally satisfactory on an individual basis, but have not been adequate for mass use. More recently, emphasis has been placed on the development of a method or methods that may be used on a large scale basis, even worldwide. This concept requires individual approval to ensure success, but the principle behind the development has been to devise methods of contraception whose practical use is simple, safe and effective. The progestins constitute an effort in this direction. Their use is very effective, moderately simple and fairly safe. They require desire, desire enough not to forget to take a pill at the proper time, with the proper interval and for the proper time. The progestins' failures are due to the side effects and, on occasion, to improper sequence of taking the pills.

History

In an effort to further simplify methods there has been a resurgence of interest (during the past five years) in an older method in which the American physician has shown little concern. This is the intrauterine ring. The principle is centuries old and may have been referred to by Aristotle when he tells how Egyptian camel drivers took steps to prevent pregnancy in their camels when crossing deserts. Through a tube, they inserted into the uterine cavity of the female camel a small, smooth stone, which was effective in preventing pregnancies.[1] The next appearance was in the form of a stem pessary, reported in 1878.[2] Richter,[3] in 1909, reported that three strands of silkworm gut placed in the uterus was an adequate contraceptive. Grafenberg,[4] 20 years later, reported his experience with silkworm gut tied centrally with silver wire. In an attempt to reduce the rate of expulsion, he encircled the gut with silver wire, forming a ring, which became known as the Grafenberg ring. Metals react with the endometrium. The ring frequently became embedded in the uterus, making it extremely difficult to remove. These problems resulted in general condemnation by American physicians. Such reticence by physicians in the United States was not shared by Ota,[5] who devised his own modification of the Grafenberg ring and reported excellent results. Interest in America apparently was stimulated by the reports of Oppenheimer,[6] of Israel, and Ishihama,[7] of Japan, who iterated the efficiency of the ring in preventing pregnancy. During the next few years a stainless steel ring[8] and variously shaped plastics[9, 10, 11] were introduced. Some of these have plastic or nylon extensions which project through the cervix into the vagina, making it possible for the patient to determine whether or not the device is still in place. The plastics are in shapes of spirals, loops (double S curve), bows (like the tie), shields and rings (Figure 1). Recently a large research center has hired a design engineer to help improve the design, so that the expulsion rate will decrease.

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Method of Insertion

If the decision to use the intrauterine contraceptive device is made at the time of delivery, place the patient on one course of a progestin, beginning two weeks after delivery. This should prevent ovulation before introduction of the intrauterine contraceptive device is accomplished. Insert the device during the last day or two of the withdrawal bleeding or immediately after it is over, in order to prevent the accident of introducing it during an early pregnancy.

After a routine physical examination, a complete pelvic examination should be made, noting the size and position of the uterus. Using sterile gloves, insert the sterile device into the sterile inserter (Figure 2). After placing a speculum in the vagina, expose the cervix, grasp it on the anterior lip with a tenaculum (not always necessary) and clean it and the vagina with an antiseptic. Sound the uterus, noting its depth (Figure 3). Insert the loaded inserter to a depth of 1 - 2 cm. less than the depth of the uterine cavity (Figure 4). If the inserter does not enter the uterus easily, use a #3 or #4 Hegar dilator for dilating the cervix. Empty the inserter by using the stylette (Figure 5). Withdraw the inserter (Figure 6).

If a Marguiles spiral is used, do not reduce the length of the tail at this sitting. The tail may extend farther or retract within the next menstrual cycle. Warn the patient about the length of the tail protruding into the vagina, so that her partner will not be injured during coitus. Have the patient return following the next period and, at that time, shorten the spiral so that two beads are palpable. Have the patient palpate the shortened spiral (Marguiles type), or the nylon threads (Lippes loop type) so that she may recognize the presence or absence of the ring.

At the second visit, when the patient is not bleeding, take a vaginal smear for cancer detection. Since there is some evidence that chronic irritation may be a concomitant stimulus in exciting cancer of the cervix, take a cancer smear every six months. At the moment there is no evidence that the plastics are irritant either to the cervix or the endometrium,[12] but it does no harm to be careful.

Detection of the presence or absence of the ring is, to me, not only of practical importance, but also of psychologic importance. The Marguiles spiral and Lippes loop have these advantages. Other devices can be located by sounding the uterus or by x-ray. These two methods are highly undesirable to me. Other methods are being attempted: A magnetized metal has been included within the plastic ring[13]; a compass is placed on the abdomen; if the compass does not point to the north, the patient has no problems; if it does, however, all systems are not A. O.K. An electronic system has recently been invented to locate concealed rings.[14] This appartus seems too large to me to be satisfactorily camouflaged for home use.

How Are Pregnancies Prevented?

No one really knows. Most everything that is known is of a negative nature. For example, there is no effect on the hormone production,[15] and the tubal motility is not interfered with.[16]

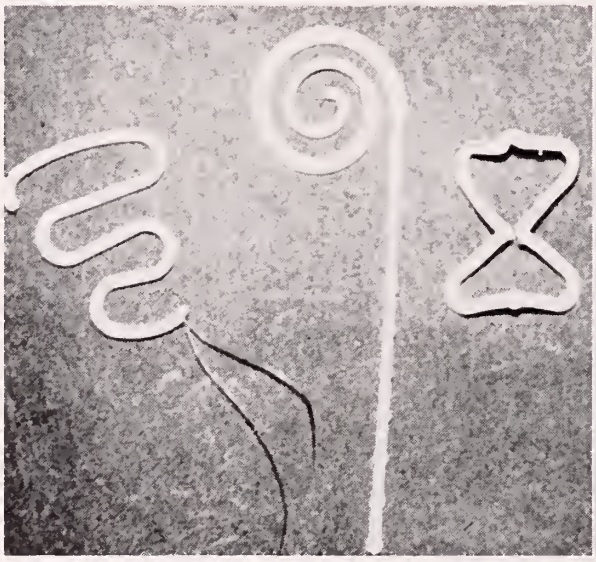

Figure 1: The Lippes loop, Marguiles spiral and Birnberg bow.

Figure 2: The inserter has been loaded with a Marguiles spiral.

In fact, very recently, an unimplanted fertilized ovum was retrieved from the intrauterine cavity in a hysterectomy specimen.[17] The transport of sperm is uninhibited.[18] There is no interference with ovulation,[19] of fertilization[20] (an ovum has been recovered from the tube). The pH of the endometrial fluid is unchanged.[21]

In some cases there is mild, chronic edometritis, but in the vast majority there is normal endometrium, at least by ordinary light microscopy.[8, 22] Doyle and Margolis[23] maintain that a foreign body in the endometrial cavity prevents decidualization in that horn of the rat in which it is placed, while in the other horn of the rat, normal pregnancy progresses with obvious decidualization. How decidualization is prevented is not known, but they suggest abnormal utilization of hormones locally due to an imbalance caused by alteration in cell permeability, or vascularity or enzymatic pattern. There may be an increase in uterine motility with the insertion of the foreign body, moving the fertilized ovum along too rapidly or implantation to occur. Studies of many types are now in progress in order to clarify the reason why pregnancies usually are prevented.

How Effective Are They?

Effectiveness of various devices has recently been recorded by using the parameter 100 years' exposure. If 100 women use a particular method continuously for one year, 100 years' exposure would be experienced. From information obtained in 1957,[24] the rate of pregnancy for 100 years' exposure was 40.8 with the douche, 38.5 with rhythm, 16.8 with withdrawal, 14.4 with the diaphragm and 13.8 for the condom. The "pill" is probably less than 1.0. Rates vary with the intrauterine devices as much as 0.9 to 6.0, depending on the type, size and other factors. Except for the "pill" they are much more effective than the other mechanical devices frequently used. The rate for normally fertile women without any contraception is about 80.0.

Contraindications

Fibroids, which distort the intrauterine cavity, acute or subacute pelvic inflammatory disease, carcinoma, acute vaginal infections, functional uterine bleeding or other menorrhagias and, finally, pregnancy, are all contraindications. Particularly, the nullipara will have much more difficulty with cramps and retention than the multipara, but she is not strictly a contraindication.

Complications

Apparently there is no medication, no diagnostic or therapeutic measure that does not have some degree of complication, no matter how slight. The intrauterine contraceptive device is no exception.

Pregnancy.—Rates of pregnancy have been discussed previously. In addition to the normal intrauterine pregnancy, extrauterine pregnancy, usually tubal, also occurs. There is no indication that the frequency is increased. One should not, however, be lulled into complacency in the presence of an intrauterine contraceptive device to forget about the possibility of an ectopic when faced with an acute abdomen in the female.

When pregnancy does occur, they may abort or carry to term. They are not teratogenic, and the ring is expelled with the placenta and the membranes. There is no interference with lactation.[15]

Figure 3: Sounding the uterus to define its depth.

Figure 4: The loaded inserter in the intrauterine cavity.

Expulsion.—As many as 20 per cent of the intrauterine contraceptive devices may be rejected by the uterus. This is the most troublesome problem, and may occur within a few days or usually with the next menstrual period. If it is rejected, it has become my policy to use a larger size of the same device and if this fails, to use a different type. Some types are tolerated better than others in different uteri. Which device has the greater chance of being retained by any one uterus can not be predetermined. The risk of expulsion after the first period decreases rapidly.

Pain.—Cramping occurs in some patients. When it occurs immediately after insertion, it may be because the plane of the intrauterine contraceptive device is not in the same plane as the endometrial cavity. By removing and reinserting the device, the crampy pain may disappear. Others have some discomfort for days, or with the next menstrual period. It can usually be controlled by mild analgesics.

Bleeding.—This is usually a minor but annoying complication. Because of the frequency of its occurence, inserting the device during the latter part of the menstrual period is advised. The period may be lengthened and heavier. It is easier to control the psyche of the female who has increased bleeding, than that of one who initiates new bleeding. On occasion it may be profuse and require hormonal control. This may be accomplished by using a large dose of an estrogen (stilbestrol mg. 5 every half hour until bleeding slows). Then give 2 mg. of the same drug daily for 20 days. Hopefully, the next bleeding will be normal. Progestins used in a similar fashion also are satisfactory. There may be some increase in amount of bleeding with each menstrual period, or there may be rather frequent spotting. Usually after the first period, these problems disappear or become acceptable to the patient.

Infection.—The intrauterine cavity is not sterile in 60 per cent of patients. After insertion of the ring there was no significant increase in the bacterial flora of the endometrial cavities that were cultured.[25] The microscopic changes that occur with protracted use show little evidence of endometritis. There will be patients with pelvic inflammatory disease, and an occasional patient may become infected, although we have not experienced it. The incidence of infection is probably no greater when the ring has a projection into the vagina. The projection apparently does not behave as an effective portal of entry for bacteria.

Effect On Fertility After Removal.—There is apparently no effect on fertility after removal.[26]

Perforation.—Perforations have been reported both at the time of removal and while *in situ*. One case of intestinal obstruction due to perforation and attachment to bowel has been reported.[27]

How Long Can They Stay In?.—The Grafenberg ring has stayed in many years, the longer it stays the greater the chance of its becoming embedded and buried. This is probably not true of the plastic devices, since they do not react chemically with the endometrium. The Marguiles spiral will retain its shape for at least eight years. Since this plastic type was first used in the late 1950's, there has been insufficient time to evaluate the question. I suspect that the

Figure 5: The inserter has been emptied of the intrauterine contraceptive device.

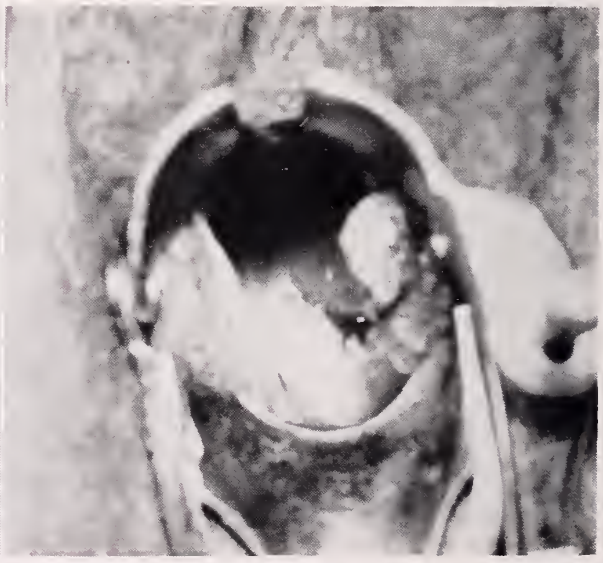

Figure 6: The tip of the Marguiles spiral protrudes through the cervix into the vagina.

plastics will cause much less trouble than the metal type and will probably need to be changed infrequently, let us say, every five years or so.

Addendum

In October, 1965, Mastroianni suggested, following experiments with the macaque, that the reason why pregnancy did not occur is because the tubal motility increased to such an extent that the ovum was not ready for implantation at the time it reached the endometrium.

Resumé

A brief description of the history, method of use, advantages and disadvantages of the intra-uterine contraceptive device is presented.

A list of references may be obtained by writing to The Journal.

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Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

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References: 1. Editorial: JAMA *191*:592 (Feb. 15) 1965. 2. Meilman, E., in Moyer, J.H.: Hypertension, Philadelphia, W.B. Saunders Company, 1959, p. 395.

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Epidermoid Carcinoma Arising in Chronic Osteomyelitis

Catalino B. Mendoza, Jr., M. D., George W. Easley, M. D., Capt. Ferdinand Leacock, M. D., (MC) USA, and Walter H. Gerwig, Jr., M. D.

CANCER occurring in an old scar has been recognized since the first century when Celsus, the Roman physician, noted its development following burns.[3] Hawkins, in 1835, described carcinoma associated with chronic osteomyelitis.[3,5] The following is a case report of a malignant neoplasm developing in a sinus tract which had resulted from long-standing osteomyelitis of the tibia.

Case Report

J. M., #05274, a 71-year-old Caucasian male, was admitted to the Veterans Administration Hospital at Clarksburg, West Virginia, April 29, 1964, because of recurrence of a draining sinus over the anteromedial aspect of the right upper tibia, of five months' duration. In 1940, he had sustained a compound fracture of the upper third of the right tibia. The original fracture site continued to drain until 1962 when, following curettage, healing occurred and there was no suppuration until just prior to admission.

Approximately two weeks following this admission, curettage of the sinus tract was performed. Histological examination of the wall of the tract and underlying bone revealed squamous cell carcinoma (Figures 1-A and 1-B). Biopsies of lymph nodes in the right groin showed metastasis (Figures 2-A and 2-B). On June 16, 1964, he underwent an above-knee amputation, performed according to the method of Campbell, followed on July 2, 1964, by right radical groin dissection. Because of a small area of slough in the skin over the inguinal region, a full thickness graft was applied on August 3, 1964. Healing was satisfactory and he was discharged two weeks later. He has been followed for one year and is well and without evidence of recurrence.

Discussion

Incidence.—Epidermoid carcinoma of the extremities comprises approximately one to two per cent of all squamous cell carcinomata. Two-and-a-half to 4.5 per cent of these are secondary to osteomyelitis and draining sinuses.[6] The incidence of cancer developing in a sinus from osteomyelitis has been reported in various series from 0.2 of 1 per cent to 1.6 per cent.[1]

Submitted to the Publication Committee, January 5, 1966.

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- Walter H. Gerwig, Jr., M. D., Chief of Surgery, VA Hospital, Clarksburg; and Professor of Surgery, WVU Medical Center.

Location.—The bone involved is usually located in the lower half of the body. More than 85 per cent of cases occur in lower extremities, with the tibia accounting for 50 per cent.[6]

Etiology.—Ruchaud, in 1905, postulated a triad for the development of cancer in scar tissue.[3] First, in order for the malignancy to be initiated, suppuration must have occurred for a long time. Second, 20 to 30 years was necessary for generation of scar tissue into cancer. Third, some type of traumatic incident caused the proliferation of the cancer. Onset has occurred as rapidly as one and one-half years, and as slowly as 64 years. In our case, the malignancy developed in 24 years. The original lesion is usually open and subject to chronic irritation.

Signs and Symptoms.—It has been found[5] that one or more of the following is suggestive of malignant change: pain that has increased or changed in character associated with increase in foul exudate, development of a mass or onset of bleeding.

Diagnosis.—Tissue for biopsy is the only definitive manner in which the diagnosis is made. It should be taken from many sites, especially from the depths of the sinus tract. The entity which is most difficult to differentiate from carcinoma is pseudo-epitheliomatous hyperplasia.

Treatment.—After the diagnosis has been established by biopsy, amputation has been generally advised as the treatment of choice.[5] The site of amputation is usually in the bone proximal

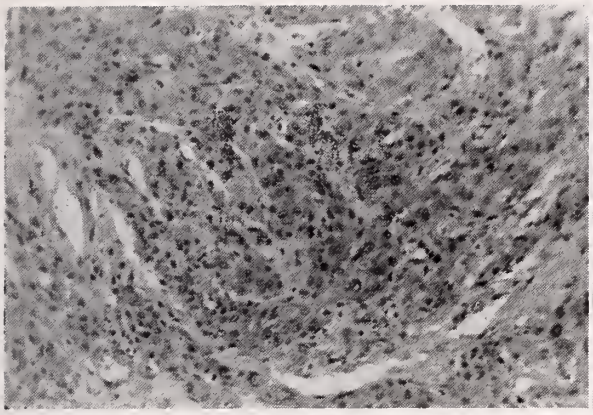

Figure 1-A. Biopsy of tibia.
(H and E stain x 100)

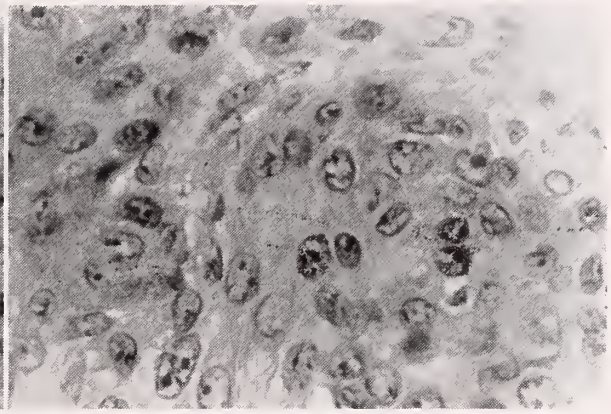

Figure 1-B. Biopsy of tibia.
(H and E stain x 500)

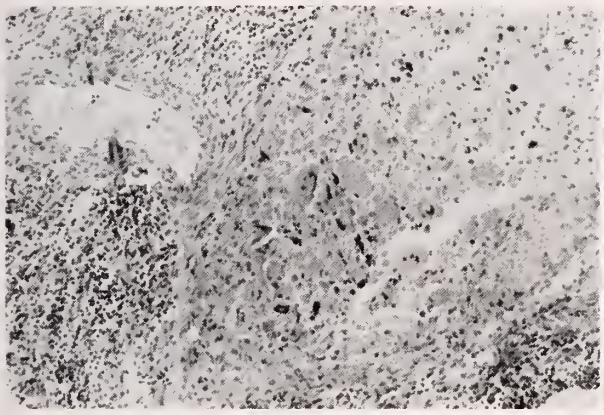

Figure 2-A. Inguinal node biopsy.
(H and E stain x 100)

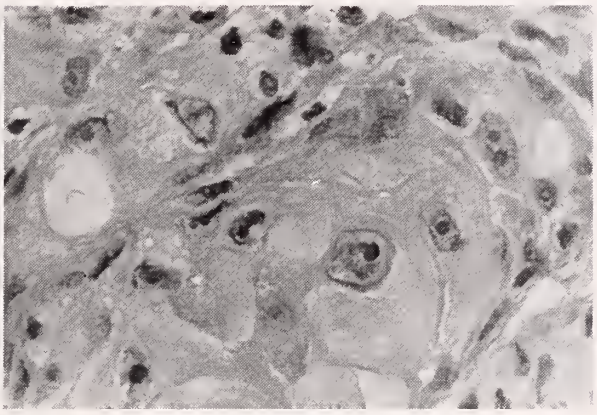

Figure 2-B. Inguinal node biopsy.
(H and E Stain x 500)

to the joint above the involved area. We feel that the regional nodes should be biopsied. If these show metastatic cancer, then a lymph node dissection should be done.

Summary

A case of epidermoid carcinoma arising in chronic osteomyelitis is reported. Salient features of this entity are discussed. This rare complication of osteomyelitis must be kept in mind when treating patients with chronically draining sinuses.

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Contraindication—History of hypersensitivity to demethylchlortetracycline.

Warning — In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of discomfort.

Precautions and Side Effects — Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg of demethylchlortetracycline HCl.

Tablets: film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

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Reversible Renal Failure and Phenacetin

James T. Hughes, M. D., and David Z. Morgan, M. D.

PHENACETIN (Acetophenetidin), a para-aminophenol derivative, is used in a wide variety of analgesics. The association of renal damage in phenacetin intake was first suggested in 1953.[1] Individual case reports of phenacetin nephropathy did not appear in the United States literature until after 1960.

Two patients with reversible renal failure associated with excessive phenacetin intake have been treated at the West Virginia University Medical Center.

The Authors

- **James T. Hughes, M. D., Resident in Medicine, West Virginia University Medical Center, Morgantown.**
- **David Z. Morgan, M. D., Assistant Dean and Assistant Professor of Medicine, West Virginia University School of Medicine, Morgantown.**

Case Reports

Case 1.—Mrs. M. B., a 52-year-old housewife, was admitted to the West Virginia University Hospital on March 20, 1962. Her husband stated that she had been taking phenacetin-containing analgesics regularly for years because of low back pain. Approximately one week prior to admission, she developed chills, fever nausea and became intermittently confused.

There had been mild polyuria for six weeks before admission. Three days before admission to this hospital, her urine had been scanty and dark.

Her blood pressure was 130/80, pulse 90, temperature 36 degrees C. She was moderately lethargic. There was bilateral flank tenderness.

Pertinent laboratory findings throughout the hospitalization as well as fluid balance are shown in Figures 1 and 2. The initial BUN was 100 mg. per cent. Adequate caloric intake was provided early in her treatment by intravenous infusions of 20 per cent Dextrose in water. Hyperkalemia was treated with a potassium exchange resin (Kayexalate).

Two months after her illness, she felt well, her BUN was 14 mg. per cent, PSB secretion was 33 per cent in 15 minutes and creatinine clearance was 91 ml. per minute.

Case 2.—Mrs. V. L., a 52-year-old housewife, was admitted to the West Virginia University Hospital on January 12, 1965. According to relatives she had been taking up to 11 phenacetin-containing tablets daily for many years because of vascular headaches. She had been admitted to her local hospital and treated for recurrent urinary tract infection and anemia on two occasions during the preceding six months. Intravenous pyelography at that time showed "moth-eaten" minor calyces, more marked on the left. Three days before her admission here she was hospitalized elsewhere with a fever of 39.0 degrees C. Her hemoglobin was 9.0 gm. per 100 ml. and white blood count 33,000 per cu. mm., predominantly polymorphonuclear neutrophils. Despite intravenous fluids and intensive antibiotic therapy, she rapidly became less alert and was transferred to the West Virginia University Medical Center.

On admission her blood pressure was 85/60, pulse rate 90, temperature 37.6° C. Her breathing was of the Kussmaul type. She was lethargic, dehydrated and cyanotic. There was an irregular tremor of her hands and arms. Her conjunctivae and oral mucosa were pale. There was bilateral flank tenderness. Candida albicans was cultured from whitish plaques in the mouth and vagina.

Some of her laboratory studies are noted in Figure 3. The initial BUN was 175 mg. per cent. The blood pH on admission was 7.290. Urinary sediment contained clumps of white blood cells as well as budding yeast forms. Culture of the urine subsequently grew *Candida albicans.*

She responded rapidly to sodium bicarbonate, 132 mEq. administered in 2000 ml. of five per cent Dextrose and water within the first 12 hours of admission. She was alert and cheerful the next morning. Her urinary output was at least 2000 ml. per 24 hours throughout her hospital stay. A transfusion of 750 ml. of whole blood was given when the hemoglobin level was 6.4 Gm. per 100 ml. An upper gastrointestinal series revealed a duodenal ulcer which probably contributed to the anemia. An intravenous pyelogram (Figure 4) showed changes in the calyces

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of the right kidney compatible with papillary necrosis combined with pyelonephritis.

She has remained well following her discharge from the hospital. Her vascular headaches have been controlled with medications which do not contain phenacetin.

Background

Spuhler and Zollinger,[1] in their original paper, noted the high incidence of medullary necrosis in their patients with nephritis, unassociated with urinary tract obstruction or diabetes. This rise in incidence was correlated with the increase of phenacetin consumption in their country.

Later reports[2, 3, 4, 5, 6] in the European and Australian literature clearly documented the frequency of renal damage among those who consumed large amounts of phenacetin. Factory workers often ingested phenacetin[7] for euphoric effect, permitting increased work capability.

Despite this, a survey of nephrologists in the United States, in 1962,[8] indicated that there was not a large number of unknown cases of "phenacetin nephritis" in this country. There was some reluctance to accept this as an entity. Since that time, however, there has been overwhelming evidence to further the association of renal damage and excessive phenacetin intake.

Clinical Pattern

A history of chronic pain from any cause associated with evidence of renal impairment should arouse suspicion. Particularly important is a history of frequent headaches as in Case 2. The first obstacle to be encountered is a reluctance of the patient to give an adequate drug-intake history. Quite often this is obtained from relatives, as it was in our two cases.

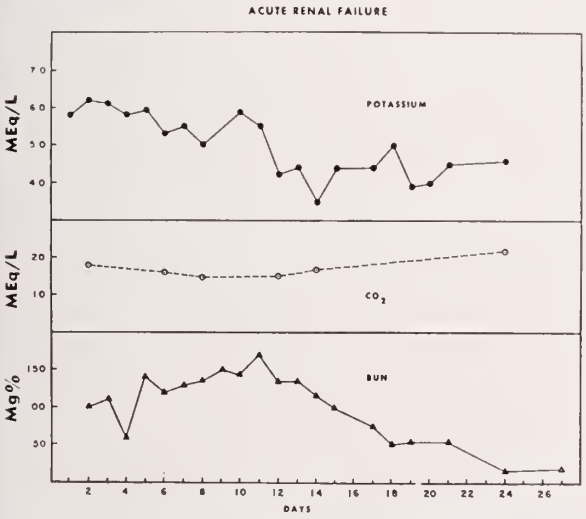

Figure 1. Case 1.—BUN rose to a peak on the 11th hospital day, even though urinary output was increasing.

The patient may present in acute renal failure with acidosis and electrolyte imbalance out of proportion to the degree of renal impairment, as in Case 2. More often the onset is insidious, with mild azotemia and anemia as in Case 1. The earliest finding is a loss of renal concentrating ability. Microscopic examination of the urinary sediment may not be remarkable but there frequently is secondary pyelonephritis. Necrotic renal papillae may be passed in the urine and may cause renal colic.

Pathophysiology

The effects of phenacetin on the central nervous system (impairment of concentration, nervousness, insomnia, tremor) have been known for years. Hematologists have long been aware

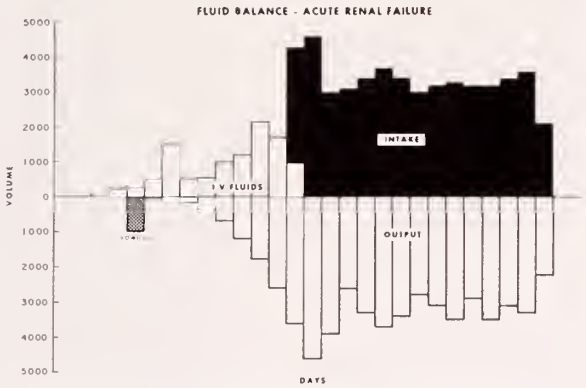

Figure 2. Case 1.—Intravenous fluids were used judiciously early in treatment to avoid circulatory overload.

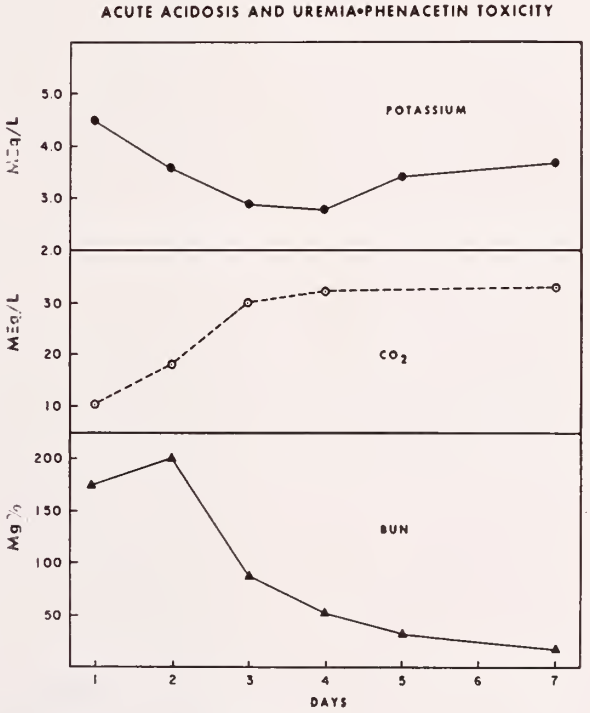

Figure 3. Case 2.—Improvement was prompt following correction of acidosis.

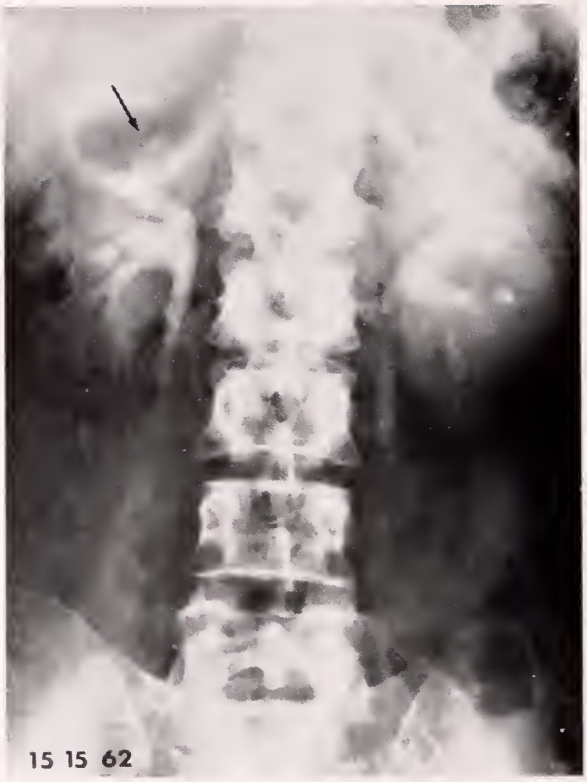

Figure 4. Case 2.—Intravenous pyelogram showing changes in the right kidney consistent with papillary necrosis.

of the occasional inducement of hemolytic anemia and the formation of methemoglobin and sulfhemoglobin by this compound.

The renal pathology [5, 9, 10] has been described as interstitial fibrosis with lymphocyte and plasma cell infiltration, thickening of the tubular basement membrane and atrophy of the epithelial cells of the convoluted tubules which contain granules of oxidized lipofuscin. There is hemorrhage and serous exudate into the renal papillae and actual papillary necrosis may occur. Glomerular or vascular involvement is conspicuously absent.

The exact mechanism by which phenacetin produces the renal damage has not been shown. The papillary necrosis is felt to be a result of impairment of medullary blood supply with coagulative necrosis. The peritubular and interstitial fibrosis is most marked in the region of the renal papillae where the urine is most highly concentrated.[10, 11]

It is not certain whether phenacetin, its breakdown products or other analgesics with which it is frequently combined[12] are responsible for the renal damage. More recently, a by-product contaminant of the manufacture of phenacetin has been implicated.[13]

Animal experiments [14, 15, 16] have not been conclusive because of the unpharmacologic doses used. It is difficult to translate the results of these experiments to man. Nevertheless, kidney lesions identical to those observed in man have been produced in laboratory animals.

Summary

Two cases of reversible renal failure which are believed to be due to excessive intake of phenacetin-containing analgesics are reported.

It is important to consider this condition in any patient with renal failure. A careful and thorough history of analgesic-intake must be obtained from the patient or relatives. Severity of the renal damage appears to be related to the total intake of analgesics.

Current knowledge regarding the pathophysiology of phenacetin nephritis and the renal histopathology are briefly summarized.

The prognosis is good unless fixed azotemia is present. Further ingestion of phenacetin must be avoided.

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Anatomy of
Low Back Pain #1

the sedentary life is often the seat of low back pain

The human spine is not engineered fo prolonged sitting at desks, pianos, type writers and drafting boards. The stresse set up by the heavy, forward-tilted hea and trunk, balanced precariously on a insufficient base, result in strain of th dorsal musculature, particularly at th low lumbar level.

The unusual muscle-relaxant and ana gesic properties of 'Soma' make it espe cially useful in the treatment of low bac sprains and strains. 'Soma' is widel prescribed ☐ **to relieve pain** ☐ **to rela muscles** ☐ **to restore mobility.**

Indications: 'Soma' is useful for management c muscle spasm, pain, and stiffness in a variety c inflammatory, traumatic, and degenerative muscu loskeletal conditions. It also may act to normaliz motor activity in certain neurologic disturbances

Contraindications: Allergic or idiosyncratic reac tions to carisoprodol.

Precautions: 'Soma', like other central nervou system depressants, should be used with cautio in patients with known propensity for taking ex cessive quantities of drugs and in patients wit known sensitivity to compounds of similar chem cal structure, e.g., meprobamate.

Side Effects: The only side effect reported with an frequency is sleepiness, usually on higher tha recommended doses. An occasional patient ma not tolerate carisoprodol because of an individua reaction, such as a sensation of weakness. Othe rarely observed reactions have included dizziness ataxia, tremor, agitation, irritability, headache, in crease in eosinophil count, flushing of face, an gastrointestinal symptoms.

One instance each of pancytopenia and leuko penia, occurring when carisoprodol was admin istered with other drugs, has been reported, as ha an instance of fixed drug eruption with carisoprodo and subsequent cross reaction to meprobamate Rare allergic reactions, usually mild, have include one case each of anaphylactoid reaction with mil shock and angioneurotic edema with respirator difficulty, both reversed with appropriate therapy In cases of allergic or hypersensitivity reactions carisoprodol should be discontinued and appropri ate therapy initiated. Suicidal attempts may pro duce coma and/or mild shock and respirator depression.

Dosage: Usual adult dose is one 350 mg. table three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white tablet and 250 mg. orange, two-piece capsules.

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Figure 4. Case 2—Intravenous pyelogram showing changes in the right kidney consistent with papillary necrosis.

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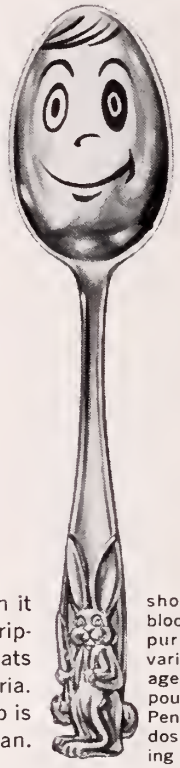

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Contraindications: Contraindicated in patients sensitive to sulfa or penicillin, pregnant females at term, premature infants, newborns during first week of life. **Precautions:** Watch for hypersensitivity reactions and overgrowth of nonsusceptible organisms. Observe usual precautions for sulfonamide therapy: adequate fluid intake; force fluids if urine volume is low; maintain urinary pH of 7 or higher; use only after critical appraisal in patients with liver or renal damage, urinary obstruction, blood dyscrasias. **Adverse Reactions:** Anaphylactoid shock (rare), G.I. disturbances, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, urticaria, purpura, hematuria, crystalluria, conjunctival and scleral varicula, petechiae may occur. **Dosage:** Daily pediatric dosage should supply 65-100 mg. trisulfapyrimidines per pound body weight in divided doses q. 4 to 6 h. **Supply:** Pentid-Sulfas for Syrup when prepared, provides 80 cc. (16 doses) or 150 cc. (30 doses) of fruit-flavored syrup providing in each 5 cc. teaspoonful 125 mg. (200,000 u.) potassium penicillin G and 167 mg. each of sulfadiazine, sulfamethazine, and sulfamerazine.

Now . . . **NEW PENTID® '400'—SULFAS FOR SYRUP** (buffered penicillin powder with sulfadiazine, sulfamethazine, and sulfamerazine each 5 cc. providing 250 mg. [400,000 units] potassium penicillin G and 167 mg. each of sulfadiazine, sulfamethazine, and sulfamerazine). Available in 16-dose (80 cc.) and 30-dose (150 cc.) bottles.

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Warning: Discontinue 2 weeks before general anesthesia, 1 week before electroshock therapy, and if depression or peptic ulcer occurs. With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.
Precautions: Reduce dosage of concomitant antihypertensive agents by one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
Side effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.
Availability: Bottles of 100 and 1000 tablets.

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Special Article

Selection of Students for WVU School of Medicine

R. F. Krause, M. D.

EACH spring *The Journal* publishes the names of those students accepted by WVU Medical School for the entering class in the fall. Perhaps you have wondered how these selections are made. Why wasn't the student I personally recommended accepted? Are grades the major criterion?

These and many other legitimate questions have frequently been asked regarding our admission policy. We feel that the physicians of this state deserve to know how we select students for medical school.

The responsibility for making these selections is delegated to the Committee on Admissions and Advancement which is composed of eight members appointed by the dean of the medical school faculty (50 per cent are M.D.'s). Five additional faculty members serve with the committee members as interviewers.

What are the criteria used for admission? Undergraduate grade point average? A high Medical College Admissions Test score? A degree in a "Premedical Curriculum?" An exuberance of extracurricular activities? How much weight is placed on the interview?

In order to answer these and similar questions, it is necessary to describe the policies and practices of the Committee. In general, the selection of students is a very individualized and selective process, with no *rigid* criteria for admission.

Each applicant must have satisfactorily completed, at the college level, one academic year of each of the following: English Composition and Rhetoric, Zoology or Biology (with laboratory), Inorganic Chemistry (with laboratory), Organic Chemistry (with laboratory), Physics (with laboratory) and Social Studies. A total of 90 semester hours, exclusive of Military or Air Science, and Physical Education is also required.

The Author

- **R. F. Krause, M. D., Ph. D., Chairman, Committee on Admissions and Promotions, and Professor and Chairman of the Department of Biochemistry, West Virginia University School of Medicine, Morgantown.**

The applicant should present a broad general education including, whenever possible, a major in some field, not necessarily a natural science. In general, the undergraduate curriculum should contain balance and depth in both the humanities and science. Today it is recognized that in order to be comfortably prepared for the study of medicine, the student should be broadly based in science.

All applicants are required to take the Medical College Admissions Test (MCAT).[1] At one time this test was believed to be a very reliable indicator of the student's intellectual capacity. Today we no longer believe this to be true but use the test as additional evidence of the individual's academic record. If there is a disparity between the student's test scores and his grade point average in college, we endeavor to determine the reason for the difference. We use these test scores in much the same way that laboratory tests are used in clinical medicine.

Today we place more credence upon grade point average than upon MCAT test scores. But here the college grade averages can be misleading. In examining the college record of the applicant, the Committee looks very carefully at the degree of difficulty he has faced in his academic career. We try not to be overly impressed by the record of a student who has played it safe by choosing unchallenging and elementary courses, thereby acquiring excellent college grades. An excess of credit hours or

1. The MCAT is currently administered twice yearly (in April or May and in October) by the Psychological Corporation at the direction of the Association of American Medical Colleges. This is an objective multiple choice test consisting of four subjects: Verbal Ability, Quantitative Ability, General Information and Science. Scores are standardized on the basis of the total number of candidates who take the examinations during a calendar year. These scores are made available only to the Committee on Admissions and Administrative Offices of the School of Medicine.

Submitted to the Publication Committee, February 3, 1966.

higher degrees does little to offset the disadvantages of low grades.

It must be emphasized, however, that the WVU Medical School has no "cut-off point" based on MCAT scores or academic record. Each applicant is carefully evaluated as an individual. Such evaluation requires people, not statistics or paper. This is the primary task of the Admissions Committee. We invite for interview all state applicants and those nonresidents whom we consider to show the most promise of being accepted. Between September 1, 1965, and January 1, 1966, we interviewed 308 applicants (115 residents, 193 nonresidents[2]).

What does the Committee look for in the interview? We search for a variety of important intangibles that help to develop leaders in medicine. We look for such qualities as motivation, breadth of interest, maturity, flexibility, dedication to aid mankind, and various other personal and social characteristics. We are especially interested in learning if the applicant has the capacity to think rather than just memorize and regurgitate facts. Considerable time is spent in judging the student's ability to get along with others and in endeavoring to measure his moral values and emotional stability.

2. Nonresidents selected by preliminary screening of approximately 1,000 Preliminary Information Forms.

The Committee also feels a strong responsibility to counsel those applicants it feels it cannot accept. This is often done by suggesting alternative fields of study or ways the student might strengthen future applications.

After the applicant has been carefully studied a decision is made to accept, to be included as an alternate, or not to accept. Each member of the committee recognizes the grave responsibility involved in making this decision; therefore, careful consideration is given to each application on the basis of college record, MCAT scores, impression of the interviewers and letters of recommendation written in the applicant's behalf. Since the Committee is charged with the acceptance of a fixed number of applicants, the final selection is on a competitive basis. Preference is always given state residents who meet our admissions requirements. All Committee recommendations are forwarded to the dean of the medical school for review and endorsement.

The Admissions and Advancement Committee takes this opportunity to thank all physicians who have directed and encouraged students to apply to our school. Since good physicians are trained from good applicants, we respectfully request your continued support in encouraging well qualified students to attend your medical school. May the foregoing information assist you in such an endeavor.

Drug Safety—Who's Responsible?

GOVERNMENT, the physician, and the pharmaceutical industry must join forces to reduce injury from adverse drug reactions. It is industry's responsibility to continue with the development of safer and more effective drugs. It is the responsibility of the physician to use drugs with discretion and to abstain from using potent and hazardous drugs for trivial conditions. It is the government's responsibility, with its virtually unlimited funds and resources, to continuously review and survey adverse experience gained with drugs from all sources and to bring these facts before physicians preferably through already organized channels of medical communication.

The government further has a responsibility to remove overly hazardous drugs from the market when usefulness does not balance off against hazard, but it must not use this authority in an arbitrary and capricious manner. The evaluation of drugs for safety is a most difficult and complex matter, and no simple formula can be devised to arrive at a conclusive opinion.—Joseph F. Sadusk, Jr., M. D.

in diarrhea

LOMOTIL® Tablets / Liquid

Each tablet and each 5 cc. of liquid contains:

diphenoxylate hydrochloride . . . . 2.5 mg.

(Warning: May be habit forming)

atropine sulfate . . . . . 0.025 mg.

is a corker

Effectiveness: Lomotil possesses a unique degree of effectiveness in both acute and chronic diarrhea.

Convenience: Lomotil is supplied as small, easily carried, easily swallowed tablets and as a pleasant, fruit-flavored liquid.

Versatility: The therapeutic efficiency, safety and convenience of Lomotil may be used to advantage alone or as adjunctive therapy in diarrhea associated with:

- **Ulcerative colitis**
- **Acute infections**
- **Irritable bowel**
- **Regional enteritis**
- **Drug therapy**
- **Food Poisoning**
- **Functional hypermotility**
- **Malabsorption syndrome**
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- **Gastroenteritis and colitis**

Dosage: For full therapeutic effect—Rx full therapeutic dosage. The recommended initial daily dosages, given in divided doses, until diarrhea is controlled, are:

Children: 3 to 6 months — 3 mg. (½ tsp.* t.i.d.)
6 to 12 months — 4 mg. (½ tsp. q.i.d.)
1 to 2 years — 5 mg. (½ tsp. 5 times daily)
2 to 5 years — 6 mg. (1 tsp. t.i.d.)
5 to 8 years — 8 mg. (1 tsp. q.i.d.)
8 to 12 years —10 mg. (1 tsp. 5 times daily)

Adults: 20 mg. (2 tsp. 5 times daily or 2 tablets 4 times daily)
*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the therapeutic dose.

Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is a Federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

SEARLE *Research in the Service of Medicine*

A message from . . .

The President

REDISTRICTING THE COUNCIL

FROM my visits to the county medical societies I have learned many things, one of which is that our old method of Councilor Districts based on Congressional Districts is outmoded and does not serve the best interests of many of our physicians and their county medical societies.

It would better serve the administrative and democratic principles of our organization if we would restudy the medical service areas of our State and recommend reorganization of our Councilor Districts along medical rather than political boundaries.

I have appointed a Redistricting Committee and requested the members to make a study of this problem and come prepared to make recommendations to the House of Delegates at the annual meeting. Dr. Kenneth G. MacDonald is Chairman of this Committee, and due to his prior service on this committee, he is knowledgeable of the problem and areas of related medical interest upon which its recommendations will be based.

The Committee on Medical Education and Hospitals, chaired by Dr. Pat A. Tuckwiller, has given detailed study to the areas of medical concentration in our State, which include medical education centers, normal routes of medical liaison and referral, and transportation. This material will be made available to the Redistricting Committee for its consideration.

There is no plan that will be entirely acceptable if it is to interrupt old boundaries, but certain changes will be necessary if we are to be a more representative organization that will recognize current medical areas of interest, and then have the foresight and courage to make those changes possible.

I ask for your careful consideration and dispassionate deliberation of the recommendations that will be presented to the delegates in August.

Seigle W. Parks, M. D., President

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

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EDITORIALS

MEDICARE IS HERE

When you receive this July issue of *The Journal* many of you will have had your initial contact with Federal Medicine. Good or bad, it is here and will become an increasing segment of your practice. No socialization scheme is ever limited in scope but tends to progress like Parkinson's Law until work is found for more and more personnel. So, you may anticipate further encroachments on your professional independence with each session of Congress.

Individuals and committees have worked many weeks to promote some understanding of the mechanism of this Law, but at this time there are many areas wherein there is total lack of understanding. To many clients, Medicare now means total medical coverage. The disillusionment will be bitter to them and will affect the preservation of good patient-physician relationship. This confusion will not evaporate readily. Some insurance companies, including Blue Shield and Blue Cross, are pursuing a policy of voiding their respective companies of major responsibility to the so-called senior citizens effective July 1. This policy has been activated with unseemly haste but private business cannot compete when government enters its field of operation.

The uncertainty of supply and the expected increase in demand for hospital beds has led the Federal government to require hospitals to delegate authority to utilization and review committees, to be sure that hospitalization is not unduly prolonged and to see that standards are established for the hospital duration of all types of illness. This will further the computer control of medicine. It is hoped that physicians on these committees realize their prime responsibility is to the sick and to their colleagues and that such committees do not become a part of hospital administration. Isn't it strange that the Federal government with its vast array of medical facilities in the Armed Forces, Veterans Administration, Indian Service, Public Health, etc., etc. only became interested in bed economy when dealing with civilian hospitals and civilian doctors? It would be interesting to have a non-governmental utilization review of Veteran Hospital facilities.

In Part B of the Medicare Law, the policies of the West Virginia State Medical Association have been reaffirmed by many County Societies and will minimize the contacts between physician and intermediary. The physicians will find many instances in their personal practice where this policy will have to be denied because of special circumstances. The means whereby the deductible $50 can be accumulated are generous and most of the deductible will go to our friends the pharmacists, so usual and customary fees will prevail without deductions shortly after

the onset of the calendar year. One can expect that customary and usual fee schedules will prove satisfactory except for a few renegades, the likes of which exist in all professions and businesses. Few, if any of us, will permit the fiscal intermediary to review our previous business in order to confirm our usual and customary schedule. Medicare is not DPA or MAA wherein overpaid administration demands service from physicians at discount rates.

It is believed that all physicians will participate in the Medicare program according to the policy of the Council of the West Virginia State Medical Association. Nonparticipation will not be helpful to physician or patient; it may appease the feeling of the physician temporarily but will not reverse the pattern. With complete utilization of Title XIX, all segments of population and profession will be involved in Medicare.

The interposition of third party between doctor and patient frequently results in animosity and indifference on the part of first and second parties, and this atmosphere can be expected to lower the quality of medical care. This has happened in all countries where government medicine has been the law of the land.

Government can build hospitals hastily but can not increase the flow of doctors and nurses within this decade unless training is so downgraded that quality suffers. So, the practice of medicine now and in the future will be limited in extent and service by available personnel.

So Be It—it's here. We hope you don't find the transition difficult. The Hippocratic Oath and Ethics of the AMA will continue to provide medical care for all the people no matter what process and pattern of service shall evolve.

The Journal would like to receive letters from its members regarding their professional attitudes and their comfort or conflict with this new era of medicine.

SOCIAL (ISTIC) NOTES

On Friday, July 1, Miss Medicare 1966 made her formal debut into the Great Society. It has been alleged that her parentage may be somewhat tainted by elements of socialistic ideals, political expediency and economic gymnastics, but despite her inheritance of these questionable genes her entrance into the national scene was supervised by no less a person than the President of these United States, with the shades of Murray, Wagner and Dingell in the nebulous background. In the receiving line one could identify such notables as Messrs. Humphrey, Cohen, Reuther and Truman. Nearly 20 million senior citizens witnessed the event with hopeful hearts and expectant attitudes. Mixed emotions were displayed by some 200,000 men of medicine whose responsibility will be the nurture and development of this precocious young lady. In the background were many millions of younger wage earners who are already feeling the increased financial pressure of demands to pick up the check for the party.

After the debut—what next? Certainly there will be marked confusion caused by overdemand and under-supply of medical and hospital facilities; there will be mix-ups and misunderstandings produced by the myriad of blanks, the miles of red tape and the flux of ever-changing regulations.

As far as our profession is concerned, one thing can and must happen. As citizens we shall obey the law of the land, and do all within our power to make this program operate in an equitable manner. By the same token, we have the responsibility of constructive criticism and the constant pursuit of those objectives which will further the time-honored relationship between patient and physician, preserve the system of free enterprise, eliminate the intervention of government between patient and physician, and, greatest of all, continue to offer the highest quality of medical care to those we serve.

TO ALL MY PATIENTS

"I did not write the medicare bill.

"I am not sure I understand it.

"I am not a government official.

"I was not trained in political economy.

"If you are not satisfied with your present, (1) medical costs or services, (2) hospital availabilities or cost, or (3) the cost of your drugs there isn't much reason to talk it over with me—I am probably as dissatisfied as you are and probably much more confused.

"There isn't much point in discussing with me the problems you have as a result of getting a whole new system of laws (regarding your medical care) to live by, because I don't yet understand what it is all about either.

"May I humbly suggest, if you have a problem (and I sincerely hope you do not) that you write your representative or senator in the United States Congress. Most of them knew enough about the law to vote for it, and perhaps since they knew so much about it when it was voted on, they can give you answers to all your questions now. I can't.

"Since my profession . . . is coming more and more under the control of the elected and appointed officials in Washington, D. C., please

do not expect me to become less and less a doctor. I can't. I won't. Therefore, the economic-legal-political questions that are troubling you should be taken to the experts in those fields for an appropriate answer.

"In the meantime, remember me as the one who treats your arthritis, your blood pressure, your aches and pains. The one who is concerned with your long and comfortable physical life and—I hope—your mental stability in these trying hours."—*St. Louis County Medical Society Bulletin.*

OUT-OF-STATE COMPETITION

A successful general practitioner in a Northern West Virginia community received an unsolicited brochure from a small town in a southern state. This community wants two doctors and offers a new office building rent-free, a rent-free residence, good schools, a new high school, staff privileges at a good hospital five miles away, fire insurance covering disability income, hospital insurance and malpractice insurance, adequate rest and recreation, cover for holidays, good roads, proximity to larger towns and a guaranteed net income of $16,000 per annum. Besides these material things the community offers love, friendliness, service and cooperation.

The communities advertising in *The Journal* for medical coverage may have to raise their rural sights to compete with this kind of out-of-state competition; however, a continuing Community Council effort in a Northern West Virginia town, after many months, did secure an excellent physician through joint effort with the West Virginia State Medical Association and the Medical Licensing Board. This physician is now thoroughly at home in this rural area.

The recent medical graduate has the whole country calling him. If your area needs a doctor, you will have to search diligently and offer community advantages not listed in our classified advertising.

TO ALL MY PATIENTS 65 AND OVER

Many of you have told me you do not intend to participate in the physicians' payment portion of Medicare (Part B). Others of you indicated that you would like to enroll in the program and have asked me of my attitude towards it. Therefore, I am writing you to inform you of my plans.

With the beginning of the "so-called Medicare" program on July 1, 1966, it will be necessary to make certain changes in our office routine in order to comply with the law, and to serve you efficiently, and not be delayed by excessive paperwork.

1. I expect to continue to practice medicine in the same manner as before.
2. We will expect you to pay for the services as before.
3. *Upon your request,* we will provide you with receipted, itemized statements during the year and at the end of *each calendar year.*
4. If it is necessary to complete additional insurance papers, there will be an additional charge commensurate with the time involved.

In order for us to give you a receipted and itemized bill, it will be necessary for you to first pay your account. Each charge and each payment will be recorded on your record. Your receipted and itemized bill may then be attached to the government form, "Request for Payment," and the government or insurance company in turn will reimburse you whatever amount you are entitled to by law.

You must remember that the Medicare program *does not cover* the first $50.00 for medical services in any calendar year and *only 80%* of the amount over $50.00. If you have private insurance, it *may* cover some of these charges.

(A) Since you may be receiving other medical services from other physicians, you *must keep* all your receipted bills and send them with your request for payment in order to prove you have paid the first $50.00.

(B) It will be necessary to set up a separate account for *each* person 65 years of age and older for *each* calendar year. We will need to have each person's medical account number.

(C) We will no longer be able to charge to your account laboratory services done *outside* our office. You must pay these charges yourself and obtain a receipted, itemized bill.

(D) It will be necessary for us to record certain medical information on your account card (bill) so that your statement will show the type of service and disease. This is required by law.

I regret these changes have been made necessary by law, but only in this manner can we continue to perform our job—which is to care for the patient.—*Kenneth O. Neumann, M. D., in The Journal of The Indiana State Medical Association.*

THE FABIAN TRIUMPH OF BUREAUCRACY

Pronouncements from Washington have deplored the predicament of the medically indigent aged. The alleged shortage of doctors and ancillary medical personnel and the reported inadequate medical facilities in so-called poverty stricken areas have been used as excuses for the need of Federal control and augmentation. This, of course, was the Fabian approach to the socialization of the health services.

Medicare is upon us, the great triumph of the socializers in this country as they have industriously infiltrated important segments of our government since World War I.

As of June 30, 1966, medicine in the United States of America was at a peak of attainment and accomplishment greater than ever before, and this came about under the system of free enterprise.

What is the future of our children who have chosen to follow us in our noble profession?

May they forgive our failures and our downfall. We allegedly need more doctors, yet doctors have now been forced into the Social Security System, and many will be tempted to retire earlier than usual. Young men of independent spirit such as have advanced medical science in the past may well be disinclined toward entering a profession where the care of fellow human beings is dictated by a bureaucrat.

Medicare has been announced as but the first step in the overall federalization of the health services. The experiences of such plans elsewhere should deter all thinking patients from wanting such here in the USA. Medicare has become the law of the land. Even its loudest proponents are now admitting that the law is imperfect. Loud cries will undoubtedly be heard from some patients when the $50.00 and the ten dollars and the five dollars required from them are extracted from their own purses, since many have come to believe that they are to receive full care under the two new systems. Medicare was thrust upon us in a manner as devious as that of the first Fabian, Quintus Fabius Maximus, who baffled Hannibal.

It is time to fight fire with fire, and we can, with intelligence, out-Fabian the Fabians. Let us most carefully study the situation and be sure we are right. We must know what is right, rather than who is right. Then as was said by Christ to his disciples, we may say to our students and followers, "Ye shall know the truth and the truth shall make you free."

All is not lost, but freedom is maintained only by the eternal vigilance and the fortitude of the brave. The future must be shaped by those who live in it, but it is feared that we of this generation may have left them a poor heritage.

THE DOCTOR'S DILEMMA

He was wound up and I just let him talk. "The trouble with medicare is that it came too soon. Nobody got ready. It isn't like the hillbilly who promised his dying wife that if he married again he would let his wife's successor use everything that she had used or had been hers, except her clothing. "Besides, I don't think your clothes would fit Rosie," he told her. The administration traded medicare for votes when it was more urgent to have the votes than the means of fulfilling the promise.

As I see it, doctors and hospitals are going to be strained to take care of a badly made pledge. One of the troubles right now is insurance. Take anybody who has a health and accident policy. They want to make sure that they get value received for the premium. They pay their insurance on their car without taking it out and wrecking it. But on their own bodies, insurance is something else. So when they pay the periodic premiums, they come to the hospital and say they have an ache here or a pain there. Most of the time they have nothing. They just know they will get a thorough medical check and the insurance will pay for it. I have heard many of them say, "Well, I got my premium back." And take a coal miner. Maybe he has something wrong with him. Now, maybe ten dollars worth of something at the drug store would fix him up. But that's ten dollars out of his pocket, so he goes to the hospital for treatment and stays there three days and when he leaves he has had a reasonably good rest and still has his ten dollars intact. Miners' welfare does that for him.

Now, if this goes on under insurance plans, what in the world will go on when all these old people figure they have something coming to them and they have to get it whether they need it or not! And there's no way in God's world of telling who has something wrong and who hasn't. You have to take each one in and go over them and, well, it just isn't going to work until you get more personnel and more hospitals.

So, medicare actually added to our troubles and our expenses."—*Jim Comstock, in The West Virginia Hillbilly.*

HOW'S THAT AGAIN?

Got a minute? Read the following paragraph.

Sect. 1813 (a) (1) . . . "(2) The amount payable for outpatient hospital diagnostic services furnished an individual during a diagnostic study shall be reduced by a deduction equal to the sum of (A) one-half of the inpatient hospital deductible which is applicable to spells of illness beginning in the same calendar year as such diagnostic study and (B) 20 per centum of the remainder of such amount. For purposes of the preceding sentence, a diagnostic study for any individual consists of the outpatient hospital diagnostic service provided by (or under arrangements made by) the same hospital during the 20-day period beginning on the first day (not included in a previous diagnostic study) on which he is entitled to hospital insurance benefits under section 226 and on which outpatient hospital diagnostic services are furnished him." (This is Part A with $20 deductible and 20 per cent coinsurance. The deductible can be credited against the $50 deductible in Part B.)

That, friends, is a section taken verbatim from the new Medicare law. It is intended to explain the formula for computing payments to hospitals for out patient services. But there is a slight problem here.

The hospitals don't understand it, the doctors don't understand it, certainly no patient will ever understand it, and the odds are at least 1,000 to 1 that no member of Congress who voted for this bill understands it either.

Somewhere, in some dark recess in the labyrinthine catacombs of official Washington, there may lurk some bureaucrat who can explain just what the above assortment of gobbledygook means. But apparently the medical profession hasn't located him yet because various hospitals and doctors are professing utter bewilderment as to the message that is supposed to be conveyed.

There really ought to be a law against such nonsense as this, but this amazing piece of bafflegab is all too typical of the language found in all too many laws and directives emanating from the federal city.

Perhaps someone could offer a prize (like, say, a free Band-Aid) to the first person who can come up with the translation and a simple explanation of what that paragraph is trying to say. Some pretty smart people have tried, however, and no one has been able to dig out the message yet.—*The Bluefield Daily Telegraph.*

MEDICINE AT THE CROSS-ROADS

Those of us who have been engaged in the private practice of medicine for longer than a few years, have learned to deal with, or ignore, many problems and circumstances that arise in connection with our practices, with varying degrees of success. Most of these circumstances or incidental problems of practice we did not learn about in medical school or postgraduate courses; we came to learn about them gradually by experience and contact with them.

Third Party Medicine, dealing with an intermediate agent—fiscal, legal or governmental—unheard of not long ago, is now the usual thing. That kind of "paper work," filling out forms, is repugnant to most of us, yet necessary now—and perhaps we should be glad to do it, to help our patients and ourselves. But it is the time consumed that annoys us—time we could use more profitably (and enjoyably) in actually seeing and treating patients, rather than the hours required for their records and forms. The time is of the essence.

This precious time, subtracted from actual patient care or from our time for study, reading, writing, or recreation, will be contracted and restricted much more after July 1 when the long-feared, long-valiantly forestalled "Government Medicine" begins. Very probably we shall have to spend much more time in record rooms, committee meetings, and taking care of paper work than in the past, with that much less time to give to clinical pursuits.

But now that "Government Medicine" or "Social Security Medicine" is here (almost), for those over 65 at least, is it not incumbent upon all of us to get along with it as best we can? We must, as loyal citizens and doctors, be determined and anxious to do our best for our patients. There is still a strange apathy and downright ignorance on the part of a great many doctors about the new Federal Health Legislation. Perhaps, like Scarlett O'Hara in "Gone With The Wind," they will put off until tomorrow thinking about anything so unpleasant.

This is something that can't be left to our "leaders"; it will affect personally every one of us, and it behooves us to know the government rules and regulations as they are developed, lest government take over completely and control the entire medical establishment, for us and for our patients, as some have stated already to be the long-term plan.—*Wendell B. Gordon, M. D., in The Internist.*

DEAN VAN LIERE RETIRES

Edward J. Van Liere, M. D., Ph. D.

The Publication Committee has received a statement from the WVU Medical Center announcing the retirement of Dr. Edward J. Van Liere from the academic rolls of the University. In the News Section of this issue of *The Journal* there is printed this announcement in full.

The Editors of *The Journal* hope that among his retirement activities the Dean will include active participation in the affairs of *The Journal.* Doctor Van Liere has been a member of the Editorial Staff for years and has been a monthly contributor to *The Journal* through research publications, special articles with particular reference to medical teaching, and through the Editorial pages of *The Journal.*

Three years ago Doctor Van Liere published a small book entitled "100 Editorials" which contained many of the Doctor's editorials that had been printed in *The Journal* over the past 20 years. The book received wide attention and Dr. William B. Bean in a review in the Archives of Internal Medicine stated: "As befits a dean, Van Liere is concerned about medical students and preprofessional training. But war, its impact and after effects, comes in for discussion. Sherlock Holmes and his creator, Conan Doyle, receive their appropriate tribute. Suicide; the bladder during weightlessness; hypoxia; women in medicine; several brief biographical tributes; the curriculum; research; alcoholism; chemotherapy—all march by on little feet."

One of the thankless duties that Doctor Van Liere has done for the State of West Virginia has been the Chairmanship of the Advisory Screening Committee in which with Gideon S. Dodds, Ph. D., and Lyle E. Herod, Registrar, he reviews the credentials of all foreign medical graduates who are applicants for licensure in West Virginia. This activity consumes endless time and can only be done by one with the world wide information on medical education of Doctor Van Liere. The Medical Licensing Board has throughout the years relied implicitly on his statements concerning the validity of medical credentials and whether the candidate complies with West Virginia Statutes.

So it is, that relief from the rigid academic duties will provide the Dean more time for his intellectual hobbies, one of which we hope will be writing more manuscripts for *The Journal.*

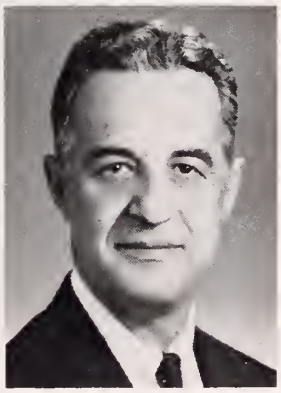
G.F.E.

GENERAL NEWS

Program Completed for Annual Meeting At The Greenbrier, Aug. 25-27

The scientific program has been completed for the 99th Annual Meeting of the West Virginia State Medical Association which will be held at The Greenbrier in White Sulphur Springs, August 25-27.

William G. Klingberg, M. D.



Nicholas W. Fugo, M. D.

Dr. Carl B. Hall of Charleston, Chairman of the Program Committee, announced that six prominent out-of-state physicians and surgeons will be the speakers at the first two general scientific sessions on Thursday and Friday mornings, August 25-26. The program for the third scientific session on Saturday morning will be presented by members of the faculty at the West Virginia University School of Medicine.

'WVU School of Medicine Day'

Five members of the West Virginia University School of Medicine faculty will participate in a Symposium on "The Problems of the Adolescent." The first half of the morning program will be devoted to formal presentations and the final half to questions and answers and general discussion. The speakers and their subjects are as follows:

William G. Klingberg, M.D., Professor and Chairman of the Department of Pediatrics (Moderator). Subject: "Introduction to the Problems of the Adolescent."

Roland E. Schmidt, M.D., Assistant Professor of Pediatrics. Subject: "Adolescent Growth and Nutrition."

Paul Davidson, M.D., Instructor in Medicine. Subject: "Specific Medical Problems of Most Importance to the Adolescent."

Nicholas W. Fugo, M.D., Chairman of the Department of Obstetrics and Gynecology. Subject: "Gynecologic Growth and Problems in the Adolescent."

Robert Vosburg, M.D., Chairman of the Department of Psychiatry. Subject: "Emotional Development and Problems of the Adolescent."

Doctor Klingberg emphasized that there will be active audience participation during the question and answer period.

First General Session

The first general scientific session will be held on Thursday morning, August 25. The speakers will be as follows:

Robert B. Greenblatt, M. D., Professor and Chairman. Department of Endocrinology, Medical College of Georgia.

John R. Haserick, M. D., Head of the Department of Dermatology, The Cleveland Clinic.

James T. Priestley, M. D., Department of Surgery, Mayo Clinic.

Second General Session

The speakers at the second scientific session on Friday morning will be as follows:

Doris A. Howell, M. D., Professor and Chairman, Department of Pediatrics, Woman's Medical College of Pennsylvania.

William M. Deyerle, M. D., Assistant Clinical Professor of Orthopedic Surgery, Medical College of Virginia.

Robert I. Wise, M. D., Professor and Head, Department of Medicine, Jefferson Medical College.

Time will be alloted for questions and answers following the presentation of each paper.

Honor Guests

Hon. Hulett C. Smith, Governor of the State of West Virginia, will be among the honor guests and will appear as a guest speaker prior to the opening of the first general scientific session on Thursday morning, August 25.

Dr. Charles L. Hudson of Cleveland, President of the American Medical Association, will be the speaker before the first session of the House of Delegates on Wednesday afternoon.

Dr. Edward R. Annis of Miami, Florida, a past president of the American Medical Association, will be the speaker at a WESPAC meeting which has been scheduled for Thursday evening.

Dr. Seigle W. Parks of Charleston, President of the West Virginia State Medical Association, will deliver his Presidential Address at the first session of the House of Delegates on Wednesday afternoon.

Dr. Richard E. Flood of Weirton, the President Elect, will be installed as President of the Association at the second session of the House of Delegates on Saturday afternoon.

Room Reservations Pass 300 Mark

The number of reservations for rooms at The Greenbrier for the annual meeting in August has passed the 300 mark and it is anticipated that more than 700 persons, including physicians, their wives and guests will be in attendance.

All physicians who plan to attend the meeting are urged to make reservations as soon as possible. An early request will assure physicians, their families and guests of room accommodations.

The complete program for the annual meeting will be published in the August issue of *The Journal.*

Conditioning Poll Results Are Gratifying

A poll on the results of pre-season conditioning for high school football players produced an overwhelming response. according to Dr. Richard W. Corbitt of Parkersburg, Chairman of the West Virginia State Medical Association's Committee on the Medical Aspects of Sports.

At a meeting of the Committee in Charleston on May 15, Doctor Corbitt reported that questionnaires had been sent to high school coaches on March 8, 1966, and the response was as follows:

1. Did you have a pre-season conditioning program? Yes (119). No (9).
2. If so, did you think the result good? Good (100). Fair (19).
3. How many sessions per day? One (82). Two (37).
4. Approximate length of each session. ½ hour (1). One hour (39). 1½ hours (14). Two hours (63).
5. Were your injuries at the beginning of the season greater or less? Same (4). Greater (5). Less (106).
6. Did you see improvement in the awkward boys? Yes (107). No (10).
7. Did fewer boys quit the squad? Yes (87). No (28).
8. Do you believe the program should be continued? Yes (114). No (2).
9. Would you prefer a one-week period instead of two? Yes (35). No (78).

The pre-season conditioning program was recommended about two years ago by the Committee. It calls for non-contact exercises prior to pre-season practice sessions to allow high school athletes to get into the best possible physical condition before the season begins.

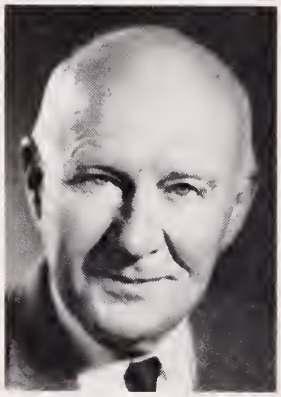
At the May 15 meeting, the Committee recommended that conditioning sessions be limited to 1½ to 2 hours a day.

No Convention Registration Fee

No registration fee will be assessed against either members or guests in connection with the 99th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 25-27, 1966.

Dr. William J. German To Speak Before Section on N.N.P.

A prominent neurosurgeon has accepted an invitation to present a paper before a meeting of the Section on Neurology, Neurosurgery and Psychiatry during the 99th Annual Meeting at The Greenbrier in August.



William J. German, M. D.

Dr. William J. German, Professor of Surgery at the Yale University School of Medicine, will speak at the Section meeting which will be held on Friday afternoon, August 26.

A native of McKeesport, Pennsylvania, Doctor German was graduated from the University of California and received his M. D. degree in 1926 from Harvard Medical School. He interned at Peter Bent Brigham Hospital in Boston, 1926-27, and served residencies at Johns Hopkins Hospital and Yale University School of Medicine, 1928-31. He joined the faculty at Yale University School of Medicine upon completion of his training and has served as Professor of Surgery since 1948.

He was certified by the American Board of Neurological Surgery in 1940. During World War II he served in the Medical Corps of the United States Navy and was retired with the rank of Captain.

Doctor German is a past president of the Harvey Cushing Society and the Society of Neurological Surgeons. He was awarded an honorary degree by Yale University in 1948.

B-R-T Medical Society Holds Postgraduate Session

The Barbour-Randolph-Tucker Medical Society held its 17th annual Postgraduate Session at the Elks Country Club in Elkins on June 16.

Speakers and their topics were:

"The Thyroid"—Joseph J. Rupp, M. D., Associate Professor of Medicine and Director of the Division of Endocrinology, The Jefferson Medical College, Philadelphia.

"Use of Estrogenic Substances, Post Hysterectomy" —Nicholas W. Fugo, M. D., Chairman of the Department of Obstetrics and Gynecology, West Virginia University School of Medicine.

"Current Status of Cancer Chemotherapy"—Alvin L. Watne, M. D., Associate Professor of Surgery, WVU School of Medicine.

Dr. Charles L. Leonard of Elkins served as toastmaster at the banquet that evening. The address was given by Dean W. Coston, Deputy Under Secretary of the Department of Health, Education and Welfare.

Mr. Coston was introduced by Sen. Jennings Randolph.

Summer Meeting of Council Held In Charleston on June 5

The Summer meeting of the Council was held at the Daniel Boone Hotel in Charleston on Sunday, June 5, 1966, with the Chairman, Dr. Albert C. Esposito of Huntington, presiding.

Primary attention was focused on the Medicare Law and the guidelines and criteria for the implementation of projects authorized by the Appalachian Regional Development Act of 1965.

It was reported that a copy of the resolution adopted by the Council at the Spring meeting had been mailed to the Chairman of the Health Advisory Committee of the Appalachian Regional Commission and to other interested officials on the state and national levels. It was further reported that an appendix had been prepared by a member of the Health Advisory Committee in an effort to clarify some of the questions which arose when the guidelines were published in March.

Doctor Esposito reported that representatives of the staff of the Health Advisory Committee had been invited but were unable to attend the Council meeting. He also said that a meeting of the Committee would be held in Washington on June 17 and that the Association had been invited to send a representative to attend the meeting.

Dr. James S. Klumpp was requested by Council to attend the meeting in Washington on June 17 for the purpose of reiterating opposition to several sections of the guidelines. It was recommended in the resolution adopted in April that certain revisions be made in the guidelines and that the proposal originally submitted by health authorities in West Virginia be reconsidered.

Medicare and Third-Party Programs

There was considerable discussion about the Medicare Law which was to go into effect on July 1 as well as the various medical programs under federal and state agencies.

Dr. George R. Callender, Jr., Chairman of the Medical Economics Committee, reported that a policy statement in re the Medicare Law had been mailed to all members of the Association in April. He suggested that several revisions were indicated to make it clear to physicians that the policy statement pertained to health care programs (Medicare) administered by the Social Security Administration.

The Council adopted the following resolution pertaining to the original policy statement approved at the Spring meeting:

WHEREAS, It is believed there will be a complexity of problems associated with the operation of Social Security-financed health care programs and it is desirable that definite statements of policy be adopted;

THEREFORE, BE IT RESOLVED, That the following definitions be adopted:

1. **Definitions.**

Usual—The "usual" fee is that fee usually charged for a specific service provided by an individual physician for his patient.

Customary—A fee is "customary" when it properly reflects the extent and nature of the services provided the patient.

Reasonable—A fee is "reasonable" when it meets the "usual and customary" criteria or, is justified under what is considered a complexity of treatment which merits special consideration. In cases where review or mediation may be requested, it is recommended that the standard mediation or review mechanism of the county medical society be utilized. Further, it is recommended that no special review or mediation committee be appointed solely to handle cases involving Public Law 89-97.

2. **Physician-Patient Relationship.**

Once the physician accepts a person as his patient, regardless of what third party might be involved, the physician's primary and sole obligation, his contract and his relationship are with the patient.

Any arrangement between the Social Security Administration and a citizen whereby the Social Security Administration agrees to pay for the citizen's medical care does not, directly or indirectly, or by inference, involve the physician in a contract with the Social Security Administration.

3. **Billing and Reimbursement.**

It is the official policy of this Association that every physician bill and receive for his professional medical services his usual, customary and reasonable fee.

The physician is requested and urged to deal directly and only with the patient, both in providing medical care and in billing for just and reasonable compensation for the medical care provided.

4. **Direct Billing vs Assignment.**

It is recommended, inasmuch as the agreement for financial responsibility is between the patient and the Social Security Administration, that the physician not accept assignment forms.

It is further recommended that each member of this Association submit to the patient his own bill and receive on his own behalf, compensation for his professional medical services.

5. **Maintenance of Quality Medical Care.**

This Association and the AMA are on record as opposing any system of medicine which would lead to a deterioration of the quality of medical care.

In assessing conditions which might lead to deterioration of this quality, West Virginia physicians are advised to give heed to Section 6 of the Principles of Medical Ethics which provides "A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care," and to the Nine Principles for Standards of Health Care programs submitted to the AMA House of Delegates, adopted by that House of Delegates and since reiterated.

Doctor Callender and Dr. Harry S. Weeks, Jr., Chairman of the Joint Conference Committee, presented a report of several meetings conducted between members of various Association sub-committees and the administrators of third-party medical programs. They reported that the administrators had

been informed that as of July 1, 1966, the State Medical Association would no longer approve fee schedules as the method of providing reimbursement to physicians for services rendered.

Doctor Callender was requested to prepare a newsletter for distribution to physicians pertaining to recommendations of the Council in regard to the billing procedure to be followed in seeking reimbursement for services rendered to patients covered by various third-party programs. It was pointed out that the action and recommendations of the Council in no way interferes with the physician's rights as an individual practitioner.

AMA Resolutions

Dr. C. A. Hoffman reported that the two AMA delegates from West Virginia had submitted two resolutions for consideration by the AMA House of Delegates during the Annual Convention in Chicago. He said the resolutions had been prepared by direction of the Council at the Spring meeting.

He said that one resolution opposes a proposed increase in AMA dues and instead calls for a complete review of the financial operation of the AMA.

He reported that the second resolution pertains to the size of the House of Delegates. He said the House of Delegates had already approved a recommendation that the growth of the House be slowed down after it reaches 250 members. He said that this rule would tend to limit the adequate representation of the smaller states in the House of Delegates.

He said that the resolving clause in the resolution to be submitted later in the month states: "Resolved, That the numerical number of 250 delegates should be interpreted to not include those delegates representing the Sections, and that, at no time, shall a state be represented by numerically fewer delegates than it has at the present time."

Election of Honorary Member

The Council elected Dr. Francis G. Genin of Clarksburg to honorary life membership in the State Medical Association.

The Council meeting was attended by Dr. Albert C. Esposito of Huntington, Chairman; Dr. Seigle W. Parks of Charleston, President; Dr. Richard V. Lynch, Jr., of Clarksburg, Vice President; Dr. Kenneth G. MacDonald of Charleston, Treasurer; Dr. L. J. Pace of Princeton, Member of the Executive Committee; Drs. Joseph L. Curry of Wheeling; Charles L. Leonard of Elkins; Maynard P. Pride of Morgantown; Andrew J. Weaver of Clarksburg; I. Ewen Taylor of Huntington; Buford W. McNeer of Hinton; W. P. Bittinger of Oak Hill; and Mr. William H. Lively, Secretary ex officio; and Mr. Edward D. Hagan, Executive Assistant.

The meeting also was attended by Dr. Frank J. Holroyd of Princeton and Dr. C. A. Hoffman of Huntington, AMA Delegates; Dr. Thomas G. Reed of Charleston, AMA Alternate; Dr. James S. Klumpp of Huntington, Parliamentarian; Dr. N. H. Dyer of Charleston, Director of the State Department of Health; Dr. George F. Evans of Clarksburg, Editor of *The West Virginia Medical Journal;* Dr. George R. Callender, Jr. of Charleston, Chairman of the Medical Economics Committee; Dr. Harry S. Weeks, Jr. of Wheeling, Chairman of the Joint Conference Committee; Mr. C. Fred Combs and Mr. Joseph A. Curia, Sanitarians with the McDowell County Health Department; and Dr. William E. Gilmore of Parkersburg.

State Medical Association Lists Names of New Members

The following is a list by component societies of new members of the West Virginia State Medical Association elected since January 1, 1966:

Barbour-Randolph-Tucker

Cook, Hugh H. Jr.	Elkins

Cabell

Branch, James C.	Huntington
Ketchum, Paul Dorsey	"
Lobo, Jaldir	"
Stacks, Donald Pressley	"
Woelfel, James Thomas	"

Central West Virginia

Ramirez, Rigoberto	Buckhannon
Wilbur, Cornelia B.	Weston

Eastern Panhandle

Palkot, John S.	Martinsburg

Greenbrier Valley

Marshall, James F.	Ronceverte

Hancock

Brancazio, Dominic A.	Weirton
Packovich, Milan J.	"

Kanawha

Horsham, Joseph	Charleston
Leadbetter, Robert L.	"
Medford, Frank E.	South Charleston
Poffenbarger, Arthur L.	Charleston
Poole, Thomas R.	"
Sayfie, Ernest G.	"
Shiels, Thomas V.	South Charleston
Steele, James L.	Nitro

Marion

Reese, Lewis C.	Fairmont

Monongalia

Dewing, Stephen B.	Morgantown
Fullmer, John L.	"
Johnson, Stancil E. D.	"
Sprinkle, Philip M.	"
Thompson, Hartwell G., Jr.	"

Parkersburg Academy

Gettliffe, Cyril D.	Parkersburg
Gruggel, John Stuart	"

Raleigh

Clopton, William M.	Beckley

Colorado Medical Meeting At Colorado Springs

West Virginia physicians have been invited to attend the 96th Annual Session of the Colorado Medical Society which will be held at Colorado Springs, September 25-28.

A complete scientific, recreational and social program is planned.

Additional details may be obtained by writing to the Colorado Medical Society, 1809 East 18th Avenue, Denver, Colorado 80218.

Dr. Edward J. Van Liere Retires After 45 Years at WVU

Dr. Edward J. Van Liere, former Dean of the West Virginia University School of Medicine and a member of the faculty since 1921, retired on July 1. (See editorial on Page 208).

E. J. Van Liere, M. D.

Doctor Van Liere, an Associate Editor of *The Journal*, reached the mandatory retirement age of 70 during the academic year which recently ended. He had served as Dean from 1935 until he reached the age of 65 in 1961. He was succeeded as Dean by Dr. Clark K. Sleeth.

"It is with most sincere regret that we note the necessary retirement of Doctor Van Liere from the active academic rolls of the University," Doctor Sleeth observed. "Under his guidance, the WVU School of Medicine moved from a position of a struggle for official recognition through development of a very strong if small two-year program to the present many-faceted programs conducted in a new and excellent facility by vigorous and enthusiastic group of faculty and students.

A native of Wisconsin, Doctor Van Liere received his M. D. degree in 1920 at Harvard. He later earned a Ph.D. degree in physiology from the University of Chicago.

Doctor Van Liere has taught more than 2,000 medical students, some of them sons of former students. He also has made extensive contributions to medical research and lay literature through the publication of more than 200 scientific articles and five books.

A book which Doctor Van Liere published on hypoxia in 1942 became required reading for all aviation medical officers during World War II. Two years ago, the University of Chicago Press published a new edition of *Hypoxia*, which Doctor Van Liere had written jointly with Dr. J C. Stickney, Professor of Physiology at WVU. Doctor Van Liere has published three other books, including one entitled *A Doctor Enjoys Sherlock Holmes.*

Another book, *Medical and Other Essays*, will be published in October.

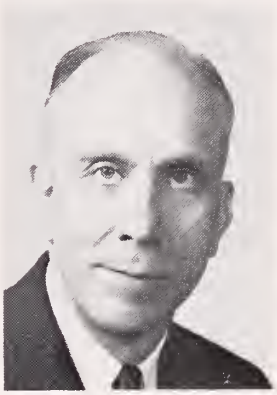
For the past five years, Doctor Van Liere has served as Dean Emeritus, Professor of Physiology and Research Professor of Obstetrics.

In recognition of his devotion to research, his interest in students, and his services to WVU, an award in Doctor Van Liere's name is presented annually to the medical student who presents the best paper on a research project.

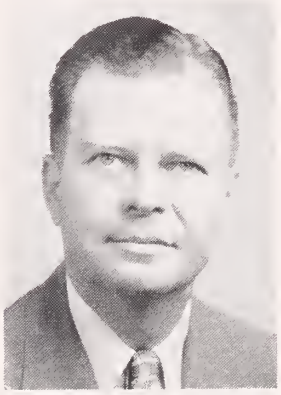
During the past 15 years, Doctor Van Liere has played a central role in the planning and establishment of the WVU Medical Center. A portrait of him hangs in the lobby of the Basic Sciences Building as a tribute to his untiring efforts.

Drs. Myers and Pollock Receive Awards

Two physicians were honored for outstanding contributions to the field of public health at the 42nd annual State Health Conference of the West Virginia Public Health Association which was held in Charleston, May 11-13.



Hu C. Myers, M. D.



Bruce H. Pollock, M. D.

State Health Director N. H. Dyer presented awards to Dr. Bruce H. Pollock, former Director of the Cabell-Huntington Health Department, and Dr. Hu C. Myers, Chief of Surgery of Broaddus Hospital in Philippi.

Each year at the State Health Conference two individuals are recognized for their outstanding and meritorious achievement in the field of public health. The Merit Award, presented to Doctor Pollock, goes to a professional public health worker, while the Citizen Award, given to Doctor Myers, honors a citizen who has contributed most to the public health program in West Virginia.

Doctor Pollock was director of the Cabell-Huntington Health Department during 1954-63. Born in Swann Creek, Ohio, in 1906, Doctor Pollock is a graduate of Marshall University and the Medical College of Virginia. He received his Master of Public Health degree from Johns Hopkins School of Public Health and served his internship at Chesapeake and Ohio Hospital. He now resides in Naples, Florida.

Doctor Myers is a graduate of Broaddus Academy, West Virginia University, and Emory University School of Medicine. He is director of the Myers Clinic, a Diplomate of the American Board of Surgery, Fellow of the American College of Surgeons, and a Fellow of the Southeastern Surgical Congress, presently serving as a member of the Council. Doctor Myers is a member of the State Board of Health.

Both physicians are members of the West Virginia State Medical Association.

Doctor Walter G. Leonard Certified

Dr. Walter G. Leonard of Elkins was certified recently as a Diplomate of the American Board of Obstetrics and Gynecology.

Water Safety Rules Listed By Doctor Dyer

Swimmers were asked to obey their natural urge to breathe and to avoid over-breathing before swimming underwater by State Health Director N. H. Dyer in a recent issue of the "State of the State's Health."

The director said that reports of accidental drownings often indicate that the victim was a good swimmer in excellent health swimming in a well-supervised pool. He noted that some of these drownings occur when underwater swimmers hold their breath too long and lose consciousness while underwater.

"Participants in underwater swim contests are especially subject to this hazard because the excitement of competition may cause them to ignore their built-in urge-to-breathe," Doctor Dyer said. He explained that the likelihood of this type of accident is increased if the swimmer "over-breathes" or "hyperventilates" before going underwater.

"Overbreathing reduces the concentration of carbon dioxide—the main trigger creating the urge to breathe," Doctor Dyer noted. "When the body's store of carbon dioxide is depleted, the urge to breathe is delayed to the point where the person's oxygen supply is insufficient. When this occurs, the swimmer loses consciousness, and, too often, drowns."

Doctor Dyer mentioned that the swimmer has little or no warning that he's on the verge of passing out. In fact, he stated, the swimmer continues to swim for a few seconds. This means that persons present—even trained water safety instructors—may not discover the victim in trouble until it's too late.

Doctor Dyer said that the West Virginia State Department of Health recommends that the state's 273 indoor and outdoor public swimming pools be utilized for recreational swimming for two main reasons: (1) Most of the streams and bathing beaches in West Virginia are not suitable for swimming because of pollutants from a chemical and/or bacteriological nature. (2) Public swimming pools generally provide adequate supervision, lifeguards, safety equipment, and a safe quality of water.

In another issue of the "State of the State's Health," Doctor Dyer reported on the Medicare program.

As of April 25, a total of 79 hospitals had filed requests to establish eligibility under the program. Dr. Dyer noted that this represents 95 per cent of all West Virginia hospitals which are potentially eligible to participate in Medicare.

Of the 79 hospitals which have already made application, he noted, 47 hold ratings from the Joint Commission on Accreditation of Hospitals. He explained that the JCAH rated hospitals have already met requirements for participation except that of utilization review. All but two of the remaining 32 have been approved and licensed.

He noted that the Health Insurance Benefits Unit of the State Health Department is responsible for providing consultation to those providers which may encounter difficulty in meeting conditions of participation. He said that after the benefit effective dates—July 1 for hospitals, independent laboratories, and home health agencies, and January 1 of next year for extended care facilities—unit personnel would offer considerable assistance to those facilities which may have failed to qualify during the initial certification period. He added that consultation will also be provided to any new institutions, i.e., extended care facilities and home health agencies which may be established after the new program gets under way.

The Advisory Committee to the Rural Health Committee met in Sutton on May 18 to plan the program for the West Virginia State Medical Association's Rural Health Conference, which will be held at Jackson's Mill next October 6. Attending the meeting were (seated) Mrs. Lynwood D. Zinn of Clarksburg, Chairman of the Committee on Rural Health and Nutrition of the Woman's Auxiliary to the West Virginia State Medical Association; Mrs. Hu C. Myers, President Elect of the Auxiliary; Dr. Martha Jane Coyner of Harrisville, Chairman of the Rural Health Committee; and Mrs. J. B. McCue of Summersville, President of the Home Demonstration Council. Standing are Dr. N. H. Dyer of Charleston, State Health Director; and Dr. Richard E. Flood of Weirton, President Elect of the State Medical Association.

Dr. George F. Evans Retires From Licensing Board

Dr. George F. Evans of Clarksburg, Editor of *The Journal*, has informed Gov. Hulett C. Smith of his retirement from the Medical Licensing Board.

Doctor Evans' last term expired on June 30, and no successor had been named by press time.

Doctor Evans had served on the MLB since its inception in 1949, and for the past three years he was chairman.

A native of Ontario, Doctor Evans received his M. D. degree in 1923 from McGill University. He is a Past President of the West Virginia State Medical Association and has served as Editor of *The Journal* since 1962.

Dr. Craythorne Heads Anesthesiologists

Dr. N. W. B. Craythorne of Morgantown was elected President of the West Virginia Society of Anesthesiologists during the Spring Meeting which was held at the WVU Medical Center in Morgantown on May 14.

Dr. Logan W. Hovis of Parkersburg was elected Vice President and Dr. Allen E. Yeakel of Morgantown was named Secretary-Treasurer.

Doctor Mazon Is New Chief At Colin Anderson

Dr. Eladio Eloy Mazon of St. Marys has been appointed Acting Superintendent at the Colin Anderson Center for Retarded Children.

The appointment was announced by Dr. Mildred Bateman, State Director of Mental Health. Doctor Mazon, a Cuban refugee, succeeds Dr. Earnest Andia, who resigned earlier this year.

Doctor Mazon has been at the center for two years. He has been clinical director for the last few months.

Doctor Mazon was graduated from the University of Havana in 1945.

Dr. Seigle W. Parks Speaks At Honors Seminar

Dr. Seigle W. Parks of Charleston, President of the West Virginia State Medical Association, gave the final lecture for the Salem College Honors Seminar in May. His subject was, "Current Trends in Medicine with Emphasis on Medicare in West Virginia."

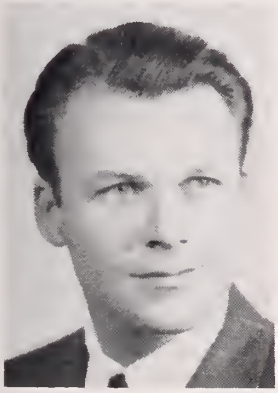
He discussed the doctor shortage in West Virginia and suggested that in order to relieve the situation, the doctor become the manager of the medical team, delegating some duties and responsibilities to others.

Doctor Parks was the dinner guest of the members of the Honors Seminar Committee.

Dr. R. W. Neilson, Jr., Joins Project Vietnam

Dr. Robert W. Neilson, Jr., a thoracic surgeon at Bluefield Sanitarium, left the United States on June 7 to participate in Project Vietnam.

Doctor Neilson will spend 60 days treating the population under a program being administered by the American Medical Association. He received his M. D. degree in 1950 from the University of Pennsylvania School of Medicine.



R. W. Neilson, Jr., M. D.

Doctor Neilson received a pre-departure briefing along with other volunteer physicians in Los Angeles on June 6. He will be assigned to one of 16 provincial hospitals.

The AMA has signed a contract assuming complete responsibility for the administration and recruiting programs for Project Vietnam. Dr. Malcom Phelps of El Reno, Oklahoma, assumed the position of field director in Saigon on July 1.

Up to 32 physicians will be needed every 60 days to fulfill the program's needs. Interested physicians should write to Project Vietnam, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Dr. Hoffman Named President Elect Of Urological Association

Dr. C. A. Hoffman of Huntington, a Past President of the West Virginia State Medical Association, was named President Elect of the American Urological Association at the organization's annual meeting in Chicago, May 30-June 2.

C. A. Hoffman, M. D.

Doctor Hoffman, who has been Treasurer of AUA, will be installed as President next year, succeeding Dr. William L. Valk of Kansas City, Kansas.

An active participant in the affairs of organized medicine, Doctor Hoffman had been elected Secretary of the Board of Directors of the National Association of Blue Shield Plans in Chicago in April. He is one of West Virginia's two delegates to the American Medical Association and sits on the AMA's Council on Medical Service. He is Chairman of the Insurance Committee of the West Virginia State Medical Association.

A native of Ironton, Ohio, Doctor Hoffman attended Marshall and Ohio State universities and received his M. D. degree in 1935 at the University of Cincinnati.

He has practiced in Huntington for 26 years.

Dr. Clark K. Sleeth Receives Honorary Degree

Dr. Clark K. Sleeth, Dean of the West Virginia University School of Medicine, was awarded an honorary Doctor of Science degree at Davis and Elkins College's commencement exercises in Elkins on May 30.

A native of Marion County, Doctor Sleeth has been associated with WVU since 1935. He served as an Instructor and Assistant Professor from 1935 to 1961 when he was named Professor of Medicine and Dean of the Medical School.

Doctor Sleeth has been active in county, state and national medical groups. He is the author of several articles in medical journals.

'Key Facts' Available

A large assortment of facts and figures about the prescription drug industry is contained in a new edition of *Key Facts* published by the Pharmaceutical Manufacturers Association.

The facts are arranged in pamphlet form under five headings: prices, competition, safety, research and accomplishments.

Copies are available upon request from: Public Information Office, Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N. W., Washington, D. C. 20005.

Dr. P. F. deGara To Address State Allergy Society

Dr. Paul F. deGara of New York City will be one of the speakers at the Annual Meeting of the West Virginia State Society of Allergy, which will be held at The Greenbrier in White Sulphur Springs on August 25.

Paul F. deGara, M. D.

The Society meets annually in conjunction with the Annual Meeting of the West Virginia State Medical Association.

Dr. Merle S. Scherr of Charleston, Secretary-Treasurer of the Society, said Doctor deGara will present a paper entitled "Importance of Teamwork Between Allergists, Other Specialists and Practitioners."

A native of Austria, Doctor deGara received M. D. degrees from Heidelberg in Germany in 1926 and from Padua in Italy in 1927. He is now serving as Clinical Associate Professor of Pediatrics-Allergy and Chief of the Pediatric Allergy Clinic at the New York Hospital, Cornell Medical Center.

Doctor deGara is a Fellow of the American College of Allergists and the American Academy of Allergy. He is a Past President of the New York Allergy Society, and his other memberships include the New York Academy of Medicine and the American Medical Association.

The meeting of the West Virginia State Society of Allergy will begin at 2 P.M. on August 25.

Other officers of the Society, in addition to Doctor Scherr, are: Dr. Marshall J. Carper of Charleston, President; and Dr. Robert S. Mutch of Fairmont, Vice President.

Medical Assistants Elect New Officers

Mrs. Betty Evans of Huntington was elected President of the West Virginia Association of Medical Assistants during the group's annual convention in Charleston, May 21-22.

Other new officers include: Mrs. Frankie Cunningham of Charleston, vice president; Mrs. Lyda Plymale of Huntington, President Elect; Miss Carroll Dickey of Huntington, Recording Secretary; and Miss Betty Keffer of Charleston, Treasurer.

Advisers include Drs. W. Edward Duling of Charleston, M. L. White of Huntington and Walter E. Klingensmith of Beckley.

Dr. Ralph J. Holloway of South Charleston was named "Boss of the Year."

Dr. Blair Heads C. of C.

Dr. F. Lloyd Blair was elected President of the Parkersburg Chamber of Commerce, effective July 1.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1966

July 7-9—Am. Med. Women's Assn., Rochester, N. Y.
July 10-14—Med. Women's Int. Cong., Rochester, N. Y.
July 15-16—Rocky Mtn. Cancer Conf., Denver.
Aug. 25-27—W. Va. State Medical Assn., White Sulphur Springs.
Aug. 29-Sept. 1—Am. Hosp. Assn., Chicago.
Sept. 8-10—Am. Assn. of Ob.-Gyn., Hot Springs, Va.
Sept. 9—Maryland Medical, Ocean City.
Sept. 16-24—Am. Soc. of Clinical Path., Washington.
Sept. 17-23—Col. of Am. Pathologists, Chicago.
Sept. 20-22—Kentucky Medical, Louisville.
Sept. 23-24—W. Va. Heart Assn., Morgantown.
Sept. 23-Oct. 1—Am. Soc. of Clinical Pathologists, Chicago.
Sept. 27-28—AMA Cong. on Occupational Health, Portland, Ore.
Sept. 30-Oct. 2—W. Va. Div., Am. Cancer Soc., Cacapon State Park.
Oct. 1-5—Am. Soc. of Anesthesiologists, Philadelphia.
Oct. 6—Rural Health Conf., Jackson's Mill.
Oct. 7-8—AMA Cong. on Medical Quackery, Chicago.
Oct. 10-13—AAGP, Boston.
Oct. 10-14—ACS, San Francisco.
Oct. 11-14—Pennsylvania Medical, Pittsburgh.
Oct. 13-15—Assn. of Am. Phy. & Surg., Disneyland, Calif.
Oct. 15—Cabell County Symposium, Huntington.
Oct. 15-16—Am. Assn. of Oph., Chicago.
Oct. 16-21—Am. Acad. of Oph. & Otol., Chicago.
Oct. 21-25—Am. Heart Assn., New York.
Oct. 22-27—Am. Acad. of Pediatrics, Chicago.
Oct. 23-26—Am. Col. of Gastroenterology, Philadelphia.
Oct. 28-30—Potomac-Shenandoah Valley PG Inst., Martinsburg.
Oct. 31-Nov. 4—Am. Assn. of Public Health Physicians, San Francisco.
Nov. 6-9—Med. Soc. of Virginia, Williamsburg.
Nov. 14-17—Southern Med. Assn., Washington.
Nov. 15-20—Am. Medical Womens Assn., Washington.
Nov. 26-27—Am. Col. of Chest Physicians, Las Vegas.
Nov. 27-30—AMA Clinical Convention, Las Vegas.
Nov. 29-Dec. 1—Am. Acad. for Cerebral Palsy, Biloxi-Gulfport, Miss.
Dec. 2-3—Am. Rheumatism Assn., Cincinnati.
Dec. 3-6—Am. Acad. for Cerebral Palsy, New Orleans.
Dec. 3-8—Am. Acad. of Dermatology, Bal Harbour, Fla.
Dec. 6-8—Southern Surgical Assn., Boca Raton, Fla.

1967

Jan. 14-19—Am. Acad. of Orthopaedic Surgeons, San Francisco.
Jan. 28-Feb. 1—Am. Acad. of Allergy, Phoenix.
Feb. 14-19—Am. Col. of Cardiology, Washington.
March 10-11—AMA Conf. on Rural Health, Charlotte, N. C.
March 9-11—AMA-ABA National Medicolegal Symposium, Miami Beach.
March 19-24—Southeastern Surgical Cong., Bal Harbour, Fla.
April 3-5—Am. Acad. of Ped., San Francisco.
April 7-9—Am. Soc. of Int. Med., San Francisco.
April 16-20—Am. Col. of Ob. & Gyn., Philadelphia.
April 17-19—Am. Assn. for Thoracic Surgery, New York.
April 23-26—W. Va. Acad. of Oph. and Otol., White Sulphur Springs.
April 30-May 2—W. Va. Chapter, AAGP, Huntington.

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Current Approach to Rheumatic Fever Prophylaxis*

John M. Hartman, M. D.

The Author

- **John M. Hartman, M. D., Department of Medicine, Memorial Hospital, Charleston, W. Va.**

The current approach to rheumatic fever prophylaxis has been carefully worked out and to a large extent is standardized. Both the initial and the recurrent attacks of rheumatic fever are precipitated by Group A streptococci; the prevention, therefore, of rheumatic fever and rheumatic heart disease depends upon control of streptococcal infections. This can be accomplished by prevention of recurrent infections in rheumatic subjects and early and adequate treatment of streptococcal infections which occur in the nonrheumatic population.

All patients with well documented rheumatic fever or with evidence of rheumatic heart disease should be given continued prophylaxis indefinitely. There is no rationale for discontinuing prophylactic treatment through the summer months. Patients with known rheumatic heart disease seem to be predisposed to recurrent rheumatic fever and these patients in particular deserve uninterrupted prophylaxis. Although the incidence of rheumatic fever diminishes with passing years, the disease can occur and recur at any age.

An extremely informative study of rheumatic fever in the adult was reported from the West Side Veterans' Hospital in Chicago by Adatto in the *JAMA* (December) 1965. Thirty-five cases of rheumatic fever, the patients ranging from 23 to 68 years of age, were included. All 35 patients fulfilled the Jones criteria of two major, or one major and two minor manifestations, the revised criteria being major manifestations of carditis, polyarthritis, chorea, erythema marginatum and subcutaneous nodules. The minor manifestations include clinical observations, as follows: a previous history of rheumatic fever or rheumatic heart disease, arthralgia or fever, and laboratory findings of acute phase reactions, i.e., elevated sedimentation rate, C-reactive protein, leukocytosis and prolongation of PR interval. These cases illustrate the changing spectrum of rheumatic fever from child to adult. Polyarthritis was present in all but one case and carditis was present in eight. Of this number there were four cases of pericarditis, while in the other four cases significant new murmurs developed. Two deaths occurred: one a 24-year-old white man with a recurrent attack; the other, a 64-year-old man with his first attack. None of these patients had chorea, erythema marginatum or subcutaneous nodules, all of which seem to be less common today, even in children, than in previous years.

This series tends to disprove the widespread notion that rheumatic fever is very uncommon in adults and, further, that it is a benign process with no serious cardiac sequelae.

Risk of Streptococcal Infections

Certain individuals run a higher risk of streptococcal infections. Among these are parents of young children, student nurses and other hospital personnel, and men in military service. The prevalence of rheumatic fever in military personnel is borne out by the study made by Frank and his co-workers at the Great Lakes Naval Training Center, reported in the *JAMA*, (September) 1965. During World War II, 21,000 cases of acute rheumatic fever were reported in Navy and Marine recruits alone in

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Submitted to the Publication Committee, February 25, 1966.

the period from 1942 through 1944. It was during this particular period that prophylaxis with sulfa was shown to result in resistant strains. Long-acting penicillin (bicillin) became generally available about 1951.

Patients who are found to have streptococcal infections should receive a therapeutic course of penicillin prior to initiation of prophylaxis. Choice of the prophylactic program to be followed is based on several factors. The best results have been obtained with intramuscular benzathine penicillin G. Monthly injections of this drug produce two effects. In the first few days following injection the concentration of penicillin in the blood is high enough to eradicate any group A streptococci which may be harboured in the nasopharynx; for the remainder of the month a continuous low blood level is maintained which prevents recurrent infection with the organism. Patient cooperation in taking oral prophylaxis is notoriously poor as is illustrated in most of the articles one reads comparing the various methods.

Oral penicillin and sulfadiazine probably are equally effective, although some strains of streptococci are found to be resistant to sulfa, particularly in streptococcal epidemics. No group A streptococcal resistance to penicillin has been reported.

Study of Prophylactic Methods

One of the large series for the study of prophylactic methods was done at Irvington House, in New York. Results of the study were reported by Feinstein and some of his colleagues and published in a series of articles in *Annals of Internal Medicine* beginning with the February, 1964 issue. The patients, ranging in age from 5 to 18 years, were transferred to Irvington House from hospitals in the New York metropolitan area. The entire group, consisting of 431 patients, was divided by random selection into three groups of approximately equal size. The patients in Group 1 received bicillin; those in Group 2 were given oral penicillin and those in the third group were given oral sulfadiazine. The patients were followed for a period of five years (1953 to 1958). A total of 285 streptococcal infections occurred among the group of 431 patients, including carriers. Of the 285 cases, 34 occurred in those taking bicillin, 113 occurred in those taking oral penicillin and 138 in those taking sulfadiazine. An effort was made to determine patient cooperation; six per cent of the group taking bicillin, 50 per cent of those taking oral penicillin and 58 per cent on sulfadiazine gave poor cooperation. In this group of 285 streptococcal infections, 48 cases of recurrent rheumatic fever were reported; all of these patients had diagnostic elevations in serum titers of one or more of the enzymes tested, antistreptolysin, antihyaluronidase and antistreptokinase. Only two occurred in those taking bicillin, 30 in those taking oral penicillin and 16 in those taking sulfa.

This study indicates an overall recurrence rate of 2.9 per cent per hundred patient years, compared to an expected recurrence rate of around 25 to 50 per cent over a similar period in the preprophylaxis era.

Summary

In summary then, listing specifically the choice of prophylaxis: first, benzathine penicillin G (bicillin), 1.2 million units intramuscularly monthly. A careful allergy study must be made and there will be a few patients who will have urticarial reactions and a clinical syndrome similar to that of serum sickness. The second acceptable method is that advocating the use of oral penicillin in doses of 200,000 to 250,000 units, taken twice daily before meals. Reactions occur with oral penicillin also but are usually of less severity than those seen with injections. The third acceptable routine is to give sulfadiazine in dosage of one Gm. daily for adults, and 0.5 Gm. daily for children under 60 pounds. Reactions to sulfa are usually of minor nature. If a morbilliform rash occurs, the drug can be continued; if it becomes urticarial, the drug usually is discontinued. If leukopenia of lower than 4,000 occurs or if the total neutrophile count falls below 35 per cent, sulfa should be discontinued. For approximately the first eight weeks of sulfadiazine therapy the patient should have a complete blood count weekly.

What about prophylaxis for the general population, that is, the nonrheumatic individuals? Three per cent of untreated patients in epidemics of streptococcal infection go on to contract acute rheumatic fever. It is highly desirable to get a bacterial culture to confirm a clinical impression of streptococcal pharyngitis. The clinical syndrome is familiar to you and usually begins with sudden onset of sore throat, headache, fever of 101 to 104 F., and, in not a few cases, accompanied by nausea and vomiting. Signs include a red throat, exudate usually does not appear the first day. There often are swollen, tender nodes, particularly at the angle of the jaw; serous otitis media and sinusitis may be concomitant findings; a scarlatiniform rash also may appear. Almost invariably a positive culture is obtained in the presence of acute infection. Here I would enter a plea for the routine use of culpac kits which are available to all

practicing physicians through their local county health departments or directly from the Bureau of Heart Disease Control, West Virginia State Department of Health, Charleston, West Virginia. This utilizes the fluorescent antibody technique for rapid identification of Group A Beta Hemolytic Streptococci. The test is performed at the State Hygienic Laboratory of the West Virginia State Department of Health, and positive tests are reported by telephone, usually within 24 hours.

During the calendar year 1965, 8,871 culpac throat culture specimens were submitted by physicians in 43 counties. Of this number, 2,769 contained Group A Beta Hemolytic Streptococci, indicating an incidence rate of 31 per cent.

Antistreptolysin titer determinations are also available on request. Both the culpac kit and the antistreptolysin titer are part of the rheumatic fever control program aimed at primary prevention of the disease.

Treatment of the acute pharyngitis should be instituted as soon as the diagnosis is established. Penicillin again is the drug of choice, one injection of long-acting bicillin is recommended (600,000-1.2 million units, depending on age and size of patient). Daily injections of penicillin are painful and unnecessary. Oral penicillin is less reliable and is quite expensive, requiring three or four tablets daily for 10 days, constituting a complete course of treatment. Erythromycin 250 mg. q.i.d. is acceptable treatment for patients who are allergic to penicillin and this, too, should be continued over a 10-day period. Tetracycline may be perfectly effective treatment, but there is a high incidence of resistant strains. Sulfonamides are not recommended for routine treatment of streptococcal pharyngitis since even long-term therapy will not completely eradicate the organism. One should bear in mind also that 25 per cent of household contacts will contract streptococcal infections, and routine screening cultures are recommended for members of the stricken individual's family in a given case.

I would like to summarize the United Kingdom and United States joint report regarding comparison of salicylates and steroids in the treatment of acute rheumatic fever. This represents a summary of 497 cases and although is not pertinent to the prophylaxis of rheumatic fever, I think it crystalizes the present opinion regarding comparison of these two drugs.

Salicylates and steroids are palliative, not curative. Neither shortens the course of the disease. There is no definite evidence that either one, given early or late, in high or low dosage uniformly terminates the activity of the process or prevents cardiac damage. Both drugs are effective anti-inflammatory agents. Steroids are more potent and usually produce a more rapid subsidence of acute manifestations. Patients with severe carditis in whose cases inflammatory edema is life threatening should receive steroid therapy.

I recommend to you two pamphlets distributed by the American Heart Association, one of which summarizes the prevention of rheumatic fever and the other is a revision of the Jones criteria for the diagnosis of acute rheumatic fever.

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A Key Site of Action of the Protoveratrine A in Salutensin

"The main function of the carotid sinus is regulation of the blood pressure...."[1]

The veratrum component of Salutensin acts here (and in the myocardium), initiating "...a reflex fall in blood pressure through a generalized vasodilation and fall in heart rate."[2]

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reserpine, 0.125 mg.

An Unusually Large Ovarian Neoplasm

(Case Report)

Antonio Palladino, M. D., Dean R. Goplerud, M. D., and Nicholas W. Fugo, M. D.

There is voluminous literature relating to papillary serous adenoma of the ovary. According to Smith (1958), this tumor comprises approximately 35 per cent of all ovarian neoplasms. The consensus is that the tumor arises from germinal inclusion cysts resulting from invagination of the surface epithelium. The cause of this process is not known but very likely is related to the fact that the ovarian cortex becomes progressively convoluted with increasing age. Dockerty (1945) reports that the neoplasm involves both ovaries in 30 per cent of cases. It rarely occurs before puberty but usually affects women between the second and fifth decades. Parsons (1961) has expressed the opinion that serous cystadenoma has a malignant potential nearly seven times greater than that of the pseudomucinous variety. A single specimen may demonstrate malignant changes in one area and not in another. In some instances, operative findings will reveal peritoneal implants, ascites and other gross evidence of malignancy which on examination in the laboratory under the microscope are entirely benign. As with ovarian neoplasms in general, this type of tumor is usually silent until it reaches large size or until ascites develops.

With the advances in surgical techniques and enlightenment of the population, more frequent medical examinations are the rule. As a result, large tumors of any kind are becoming more of a rarity. Consequently, we feel it is of interest to report this large ovarian neoplasm.

Case Report

Mrs. T. D., West Virginia University Hospital No. 13-87-32, was a 44-year-old G.i P.i who was admitted to the hospital on October 10, 1964, with the complaint of swelling of the lower left leg, of three weeks' duration. Her family physician had advised a low salt diet and had prescribed oral diuretics. She failed to improve on this regimen and was referred to the University Hospital. On admission, the patient stated that she had been extremely obese most of her life. She weighed 230 pounds at 22 years of age and had gained continuously up until the present time. She had consulted many physicians because of her progressive weight gain and had been repeatedly advised to diet, which she had done, although without benefit.

Submitted to the Publication Committee, December 30, 1965.

The Authors

- Antonio Palladino, M. D., Dean R. Goplerud, M. D., and Nicholas W. Fugo, M. D., Department of Obstetrics and Gynecology, West Virginia University School of Medicine, Morgantown.

Past history revealed that her mother had diabetes mellitus and her brother died of carcinoma of the stomach at the age of 52.

The patient had previously been treated for hypertension at the age of 30. Menarche occurred at age 13, menstrual periods are regular, occurring approximately every 28 days with five days of painless bleeding. When 22 years of age, she was delivered of a full term living male infant who survived and is presently in good health.

Physical examination revealed a cooperative woman who was 165 cm. in height, weighing 154.7 kilos (340.5 lbs), with a moderate amount of facial hirsutism. BP was 160/118, pulse 120, respirations 16. She was afebrile. The chest was clear to percussion and auscultation. Cardiac sounds were normal; no murmurs were heard. Abdomen was extremely large measuring 165 cm. in circumference at the level of the umbilicus, and she had a very large edematous panniculus. The skin of the abdomen was covered with multiple striae (Figure 1). The lower extremities were asymmetrical due to marked pitting edema involving the entire left leg. No cyanosis was present. Homan's sign was negative.

Pelvic examination revealed a parous introitus with a normal vagina and cervix. The corpus was felt to be anterior but could not be outlined because of an enormous abdominal mass. Our impression was a large ovarian neoplasm. Ex-

ploratory laparotomy was decided upon. Laboratory findings were as follows: Hemoglobin 13.5 Gm., WBC 12,200, BUN 14 mg. per cent, blood sugar 110 mg. per cent. Total serum proteins were 6.5 Gm. A/G ratio 3.7 to 3.8. Blood electrolytes were all within normal limits. Twenty-four hour urinary output of 17-ketosteroids and 17-hydroxycorticoids was 9.1 mg. and 12.7 mg. respectively. X-ray of the chest was reported as normal. EKG revealed a T-wave abnormality with a depressed V_3 and V_6 and a sinus rhythm.

The operation was performed on October 19, 1964, under general anesthesia. Total abdominal hysterectomy and bilateral salpingo-oophorectomy with elective appendectomy were accomplished without incident. A large, well encapsulated, smooth, cystic tumor arising from the right ovary and occupying the entire abdominal cavity was encountered.

Because of the patient's obesity and the large size of the tumor, we anticipated difficulty in removing the neoplasm intact. This we deemed of utmost importance in view of the possibility of malignant changes and our wish to avoid seeding of the peritoneal cavity with viable neoplastic cells.

Consequently, a midline longitudinal incision was made above the panniculus to the xyphoid. Attachments of the tumor to surrounding structures were clamped, cut, ligated and completely freed, with the tumor lying in the peritoneal cavity. A sterile-draped instrument table was then wheeled adjacent to the operating table and with sterilized cotton gloves over rubber ones to ensure a better hold, the intact tumor was slid out of the abdomen on to the instrument table.

The corpus was small, containing leiomyomata. The left tube and ovary appeared normal. There was no evidence of ascites or peritoneal implants. Blood loss was minimal. The patient's condition remained satisfactory throughout the entire operative procedure. The specimen weighed 44 kilos (98.6 lbs.) and was 190 cm. in circumference, with a diameter of 60 cm. (Figure 3) when removed.

Figure 1. Lateral view of patient on admission to West Virginia University Hospital.

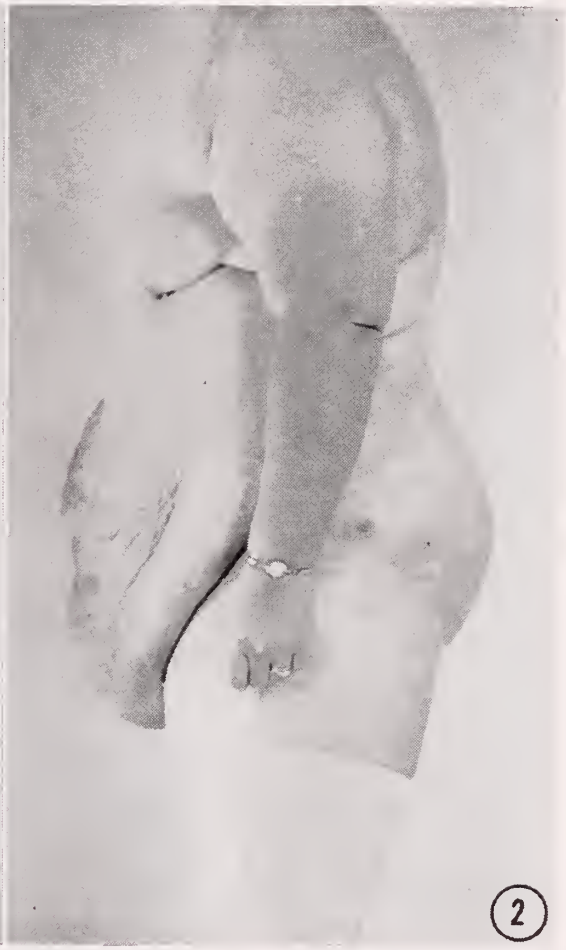

Figure 2. Lateral view of patient on discharge from hospital.

The tumor was found to be unilocular and contained clear, watery fluid when opened. Microscopic examination of the cyst wall showed the inner surface to be lined by a single layer of columnar epithelium intermingled with small papillary structures with a core covered by a single layer of columnar cells (Figure 4). The patient's postoperative course was asymptomatic and uneventful. She was discharged on her 10th postoperative day, weighing 110.8 kilos (243.7 lbs.), approximately 97 lbs. less than she weighed on admission (Figure 2).

Figure 4. Microscopic section of tumor. Note the cyst wall which is composed of fibrous connective tissue. The inner surface is lined with a single layer of columnar epithelial cells and focal areas of papillary excrescences.

Discussion

The pseudomucinous type of ovarian neoplasm usually reaches a much larger size, but this case demonstrates that a very large neoplasm may be found which is serous in nature. Approximately five per cent of the pseudomucinous form become malignant while with the serous type the percentage of malignancy is much higher. Because of this fact, we feel that every effort should be made to remove the tumor intact. The potential hazard of contamination of the peritoneal cavity by malignant cells when the tumor is tapped is extremely great. We feel that the much discussed postoperative syncope which is supposedly a factor in morbidity due to sudden decrease in abdominal pressure was not a serious factor.

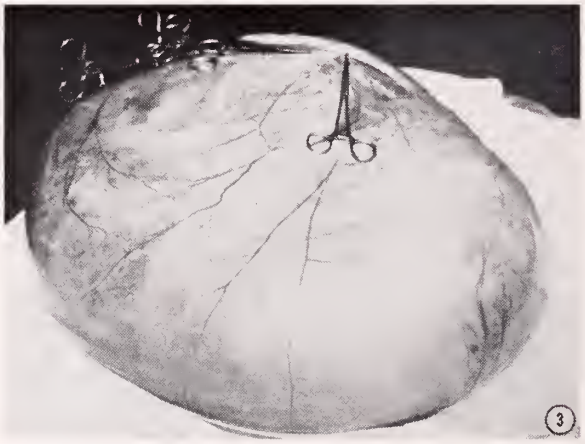

Figure 3. Serous cystadenoma on removal. Instruments are 6-inch Kochers.

We furthermore wish to emphasize the fact that in a patient of this age (at or near the climacteric), it is wise to remove the contralateral ovary along with the corpus since it is very difficult to ascertain if malignancy is present in the other adnexa at the time of surgery.

Summary

Removal of an unusually large, 44 kilo (96.8 lb.), papillary cystadenoma of the ovary, without incident, is reported. We feel that this is one of the larger tumors to be seen in modern day gynecology.

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Private Research for Public Health

PROGRESS in the (pharmaceutical) industry depends on research and development. The drug firms spent $298 million for research in 1964, compared with $282 million in 1963. In 1966, expenditures for research are expected to reach $370 million. The main products concerned have been psychotropic drugs, new preparations to combat cancer and degenerative diseases, and compounds especially used by aging patients. An intensive search into the physiology of reproduction is yielding important and improved drugs in this field. —Morris Fishbein, M. D., in *Medical World News.*

The human spine is not engineered for prolonged sitting at desks, pianos, typewriters and drafting boards. The stresses set up by the heavy, forward-tilted head and trunk, balanced precariously on an insufficient base, result in strain of the dorsal musculature, particularly at the low lumbar level.

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Side Effects: The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

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Dextro-amphetamine sulfate: Use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised; especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of pre-existing symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dose—operation of motor vehicles, machinery or other activity requiring alertness should be avoided. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia, the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor, and respiratory collapse.

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Use of the Fluorescent Antibody Technique In the Diagnosis of Actinomycosis

John M. Slack, Ph. D., Dane W. Moore, Jr., M. S., and Mary Ann Gerencser, Ph. D.

Two cases of cervicofacial actinomycosis were diagnosed directly by means of the fluorescent antibody technique using conjugated antiserum specific for *Actinomyces israelii.* Reports of the two cases follow.

Case Reports

Case 1.—The patient is R. G. (Figure 1), a 21-year-old white male who had had a first bicuspid of the right mandible removed. In one week, swelling of the jaw had developed and had persisted without drainage for four months. Examination of aspirated pus showed sulphur granules and smears stained with conjugated antiserum specific for *Actinomyces israelii* showed positive fluorescing filaments. Cultures were positive for *A. israelii.* With the exception of the swelling of the right mandible, all other clinical findings were essentially normal. Treatment using penicillin G and tetracycline over a period of six months was successful.

Case 2.—W. S., (Figure 2). The patient is a 44-year-old white farmer with a history of a "barley tuft" caught in back of his throat followed by a small lump developing on the right side of his neck which gradually enlarged over a period of four months. There was no drainage until late in the fourth month. No granules were observed. Direct smears showed Gram positive branching filaments (Figure 3) which fluoresced with conjugated antiserum specific for *A. israelii* (Figure 4). Cultures were positive for *A. israelii* associated with *Staphylococcus* and *Streptococcus.* All other clinical findings were essentially normal. Treatment with Ampicillin was initiated.

Antiserum for the fluorescent antibody procedure was prepared by immunizing rabbits with a killed suspension of *Actinomyces israelii* (ATCC 10048). The globulins were salted out with ammonium sulfate and then conjugated with fluorescein isothiocyanate following the procedures of Cherry et. al.[1] and of Nairn.[3] This antiserum was made specific for *A. israelii* by sorption with *A. naeslundii.* The use of such antiserum for *Actinomyces* was first reported by Slack and Moore.[4]

Submitted to the Publication Committee, February 14, 1966.

The Authors

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- **Dane W. Moore, Jr., M. S., Assistant Professor of Medical Technology, West Virginia University Medical Center, Morgantown.**
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Direct smears were prepared from the exudate, air dried, heat fixed and stained 30 minutes with the conjugated antiserum. After washing and mounting, the smears were observed with a Leitz Ortholux microscope using an Osram CS150 mercury vapor lamp, a BG-12 barrier filter and an O G 1 eyepiece filter. Fragmented and branching filaments fluoresced brightly (Figure 4).

Cultures were grown, using serial dilutions in brain heart infusion deeps along with streak plates on the same medium. The latter were incubated in a jar containing 95 per cent N and 5 per cent CO_2. These plates were observed microscopically at 100 x magnification at 24-hour intervals.

Typical spider colonies (Figure 5) in the first case were observed in 24 hours; in the second case, in 72 hours. Compact colonies with radiating filaments were observed in the deeps after 4-7 days of incubation.

Actinomyces israelii is characterized by being a microaerophilic, Gram positive, filamentous organism. On brain heart infusion agar it produces spider colonies (Figure 5) in 18-24 hours and "molar tooth" colonies (Figure 6) after 5-7 days. On agar deeps it grows in a zone beneath the agar and produces bread crumb type colonies in thioglycollate broth. The organism is catalase negative, reduces nitrates to nitrites, does not produce indole nor hydrolyze starch. Fermentation reactions are variable but most strains will at least ferment glucose, mannose and raffinose.

Figure 1
Figure 1: Case R. G. Cervicofacial actinomycosis.

Figure 2
Figure 2: Case W. S. Cervicofacial actinomycosis.

Figure 3
Figure 3: Gram stain of direct smear showing branching filaments.

Figure 4
Figure 4: Fluorescence of A. israelii in direct smear of exudate from jaw.

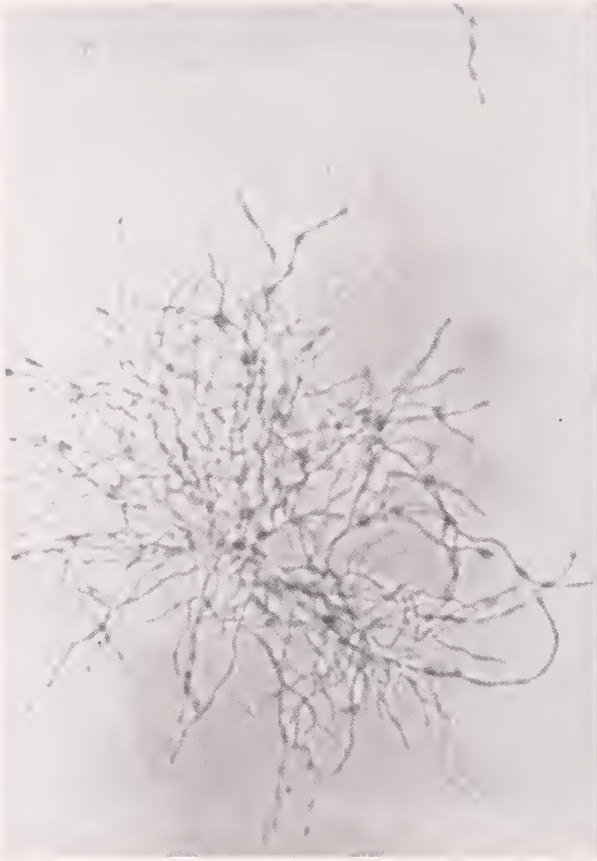

Figure 5
Figure 5: "Spider" colony of A. israelii.

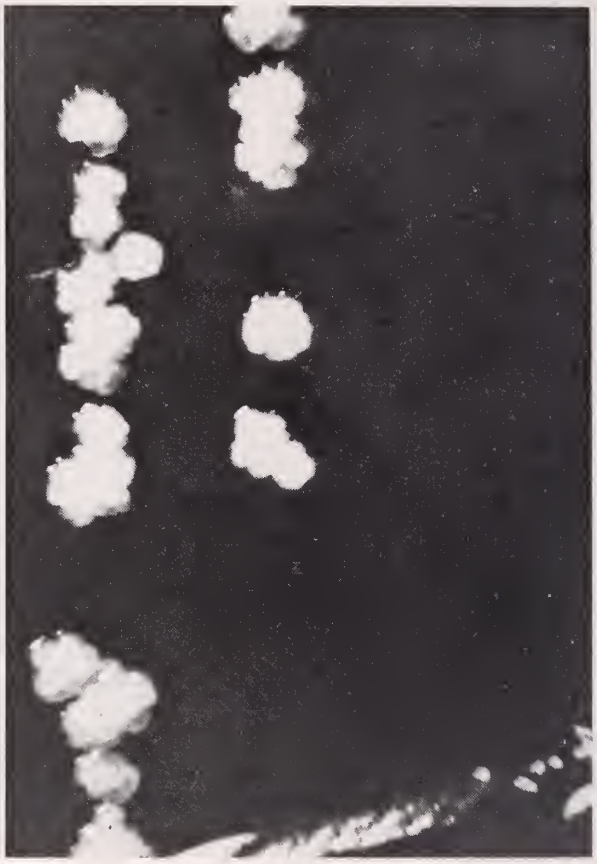

Figure 6
Figure 6: "Molar tooth" colonies of A. israelii.

Discussion

Both cases represent a common history in actinomycosis in that there frequently is a predisposing traumatic injury which allows the *Actinomyces*, found normally in the oral cavity, an opportunity to grow and multiply in the traumatized tissue. It should be emphasized that *A. israelii* has not been isolated from grains or grass and thus even though as in the second case there is a history of contact with such plant matter this acts solely as a traumatizing agent. The organism has been isolated from the oral cavity in man (including the tonsils) by a number of observers including Emmons.[2]

The specific diagnosis of actinomycosis frequently is difficult to make but this is facilitated by the careful and repetitive collection of pus or exudate from the site and a clear designation to the laboratory that actinomycosis is suspected. If the latter is not done the organisms will be missed with routine methods of examination and cultivation. However, with adequate material and information any bacteriological laboratory will be able to isolate and identify the organism. If conjugated antiserum is available the organisms can be identified in the direct smear by use of the fluorescent antibody technique which thus provides a means of early specific diagnosis.

Summary

1. Two cases of cervicofacial actinomycosis are reported.

2. *Actinomyces israelii* was identified in direct smears in both cases, using the fluorescent antibody technique.

3. The two cases of cervicofacial actinomycosis are the first such cases to be reported as being directly diagnosed by this method.

4. Methods of cultivation are briefly outlined.

5. *A. israelii* was isolated and identified morphologically, serologically and physiologically from both cases.

Acknowledgments

The authors wish to thank the following who participated in the diagnosis and treatment of these cases: Drs. J. L. Campbell and R. G. Ogilvie of Oral Surgery; Drs. A. L. Watne and

E. S. LaPlante of Surgery; Dr. E. E. Kelln of Pathology; Dr. E. W. Chick and Mr. D. S. Bauman of Health and Preventive Medicine. This work was in part supported by the Public Health Service Research Grant AI-01801-09.

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Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

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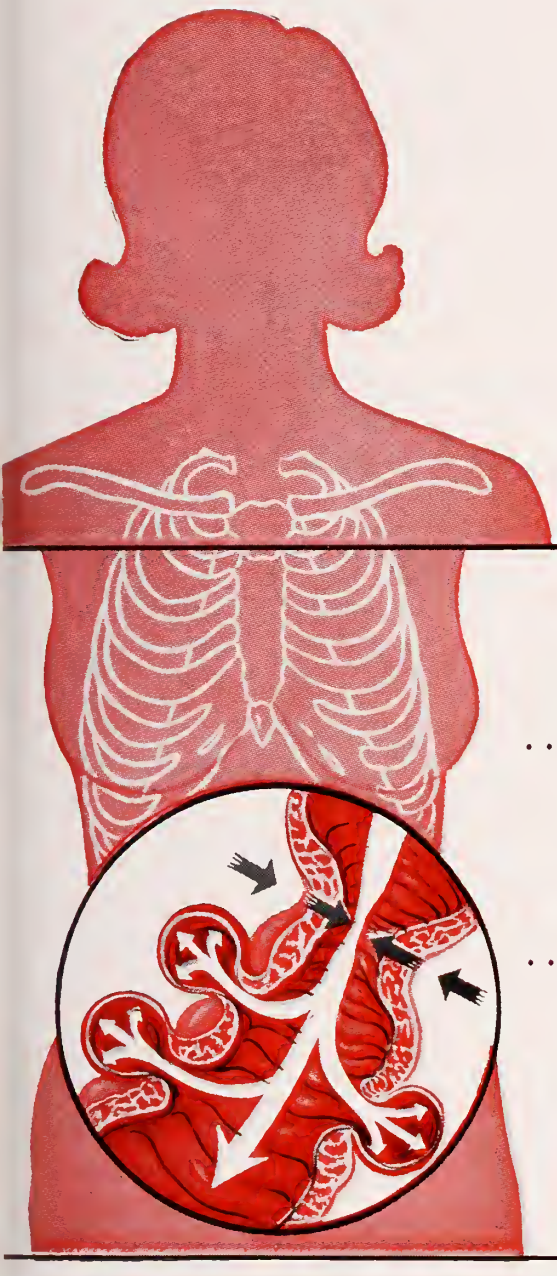

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The President

ANOTHER PAGE

ANOTHER page has been turned in the annals of the West Virginia State Medical Association. What is past is history and so let it be written. Out of the ashes of the past a new administration will be born to take over the reins of office. May I wish Godspeed and success to our new incoming President, Dr. Richard E. Flood, and offer him my full support and cooperation.

From the vantage point of time, little may be remembered about 1966 except that was the year that Medicare was forced upon the public and the medical profession as the greatest social experiment of our times. The mirror of time perhaps will also reflect that 1966 was the year that our organization was placed on a sound fiscal basis with a balanced budget, adequate financing and the Treasurer in an active capacity. Although it may not be long remembered, a major emphasis was placed upon the necessity to improve the communication and cooperation with the county medical societies in order that they might be strengthened and be made a more active integral part of the State Medical Association. Recommendations were made to the Redistricting Committee and it was asked to present a resolution to the House of Delegates for your consideration.

The continued growth and success of any organization depends upon the united efforts of many knowledgeable and unselfish workers striving for a common goal. It is to these many loyal friends I wish to express my gratitude. I have only the greatest praise and admiration for Mrs. Wilson P. Smith, President of our Woman's Auxiliary. Her outstanding leadership has brought the Auxiliary to a new high level of service and recognition. With the known risk of selecting but a few for special praise, I wish to pay tribute to several to whom we are all indebted. The Executive Committee, feeling the weight of its responsibility, has met before each Council meeting to discuss and organize the material in order that the Council could handle its meeting in the most expeditious and efficient manner.

Dr. George R. Callender, Jr., Chairman of the Medical Economics Committee, has served his State Medical Association in a most outstanding manner in strongly defending the House of Delegates' position on usual and customary fees. Largely through his efforts, successful agreements have been established. Dr. Harry S. Weeks, Jr., as Chairman of the Joint Conference Committee with the Department of Welfare, has been most successful with his negotiations with the Commissioner, Mr. Lon Vincent. Many committees deserve special commendation but to mention only one more the outstanding work and planning of the Committee on Medical Education and Hospitals headed by Dr. Pat A. Tuckwiller should be pointed out. I also wish to thank Dr. Carl B. Hall and his Committee for the arrangement of such outstanding speakers for our Scientific Program. Their prominence should guarantee a maximum attendance.

Only those of us who have had the privilege of working closely with our headquarters staff are fully aware that we owe so much to so few. It has been a sincere pleasure working with our always congenial and helpful Executive Secretary, Bill Lively, and his co-worker, Ed Hagan. Special thanks go to Mary and Judy for their excellent work and assistance.

As my wife, Eleanor, served her term of office as President of the Auxiliary, she has been most understanding and to her and my family I owe a special thanks for their support and encouragement.

The Chesapeake and Potomac Telephone Company of West Virginia has certainly been a very important part of the team and has granted me all the time that was necessary to carry out my responsibilities. My sincere thanks to my very efficient staff which has carried on during my time out of the office.

I thank you all for the opportunity you gave me to serve my fellow doctors and our organization. It is an honor I shall always humbly cherish.

Seigle W. Parks, M. D., President

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EDITORIALS

JOIN US AT THE GREENBRIER

The 99th Annual Meeting at The Greenbrier later this month promises to be one of the finest in the long history of the West Virginia State Medical Association. The program for the three-day meeting offers something of interest to every practicing physician as well as members of the Auxiliary and guests.

We call to your attention the detailed convention program which appears elsewhere in this issue of *The Journal.* We feel sure you will join us in congratulating the Chairman of the Program Committee, Dr. Carl B. Hall of Charleston, and the other members, Drs. William E. Gilmore of Parkersburg, William G. Klingberg of Morgantown and Halvard Wanger of Shepherdstown.

Once again this year the Program Committee has succeeded in obtaining some of the nation's most prominent physicians and surgeons as speakers for the scientific sessions. Also, it will be a privilege to have with us the following honor guests:

Dr. Charles L. Hudson of Cleveland, President of the American Medical Association.

Dr. Edward R. Annis of Miami, Florida, a Past President of the American Medical Association.

Hon. Hulett C. Smith, Governor of the State of West Virginia.

Doctor Hudson will speak at the first session of the House of Delegates on Wednesday afternoon, August 24, and Governor Smith will be

Seigle W. Parks, M. D.
President

the first speaker at the general session on Thursday morning, August 25. Doctor Annis will deliver an address at a WESPAC meeting on Thursday night.

The Medicare Law will have been in effect for almost two months at the time of the meeting and it will be interesting to hear the observations of these men who have been so directly concerned with the implementation of the law.

Dr. Seigle W. Parks of Charleston, President of the State Medical Association, will complete his term of office following a busy and most productive 12 months. He made it a point to visit every component society which extended an invitation and there was never a week which didn't find him traveling throughout the State.

When he took office last August, Doctor Parks stated his primary goal was to strengthen the county medical societies and improve communications between the local and state organizations. During his appearances before county societies he departed from the customary formal presentation and devoted the time allotted to a frank discussion with active question and answer sessions. We believe he was highly successful in achieving the goals he set for himself last year.

Doctor Parks will turn the gavel over to another capable physician at the final session of the House of Delegates on Saturday afternoon. Dr. Richard E. Flood of Weirton has served organized medicine for many years and will provide leadership of the highest caliber during the coming year.

The Program Committee has extended a cordial invitation to members of the Woman's Auxiliary and guests to hear the addresses by the honor guests as well as the addresses by Drs. Parks and Flood.

The Woman's Auxiliary is in charge of the entertainment program again this year and a "Dixieland Ball" will be held in Chesapeake Hall on Friday evening. A reception honoring the officers of the State Medical Association will be held on Saturday evening. Physicians, their wives, guests and representatives of our industrial exhibitors are invited to attend both the dance and reception.

As in past years, we urge physicians to set aside ample time for a complete tour of the Exhibit Center. A record number of industrial and scientific exhibits will be on display and the representatives of the many companies which help to make the meeting possible will be most happy to discuss their products and recent therapeutic developments.

With few exceptions, the representatives of our exhibitors have been greatly pleased with physician interest during the past two years. Certainly the exhibits play an important role in the success of our annual meetings.

If you have not made your reservation at The Greenbrier, we urge you to do so immediately. Reservations as of this date have passed the 450 mark and it is anticipated that the total attendance will exceed 700. Requests for room accommodations should be mailed directly to the reservation manager.

We'll see you at The Greenbrier!

AN ITEM OF REASSURANCE

At the June Council meeting you will recall there was some definite criticism of the Guidelines prepared by its Health Advisory Committee and approved by the Appalachian Regional Commission. Council's objections, concerned primarily with the possible misinterpretation of the first sentence in Resolution No. 62, were transmitted to ARC headquarters in Washington and within a few days we were informed that the steering committee of the Health Advisory Committee agreed that clarification was required.

In an interview with *The Charleston Gazette's* Washington Bureau, a "spokesman" for HAC then reportedly stated that no changes would be made. Nevertheless, this writer was sent to Washington for a personal appearance before the HAC on June 17. We were given a pleasant reception and a prepared statement was read which cited our reasons for objection to Resolution No. 62 as then promulgated. We were very much impressed by the sincerity, devotion and understanding shown by the members of HAC. We spent an hour with the Committee and on our departure we had neither negative nor positive assurance of any compliance with our request for clarification.

On Saturday, June 18, however, we were informed by telephone that HAC would recommend to the Commission that the following statement be added to the "WHEREASES" of Resolution No. 62 just before the "RESOLVE." —"The purposes of these projects are to improve the general health of the area, to increase the availability of health services, and to demonstrate that it is possible to provide modern, comprehensive care in a variety of regions of Applachia with careful evaluation of each demonstration project. The development and operation of any community health service under Section 202 shall preserve and encourage all existing

programs and arrangements involving the relationship between the physician and the patient."

The last sentence in this statement contains the clarification we sought, and should assure the medical practitioners in Appalachia of the firm intentions of the Regional Commission in matters relating to community public health services in the 12-state area. The immensity of the general problem and the intent of developing such services in a detailed and comprehensive manner would seem to indicate an effort over several years required for fulfillment.

The fact that federal funds are provided on a pro-rata basis for only a limited time will require the appropriation of large amounts from state and local sources. These requirements will not generate any undue speed in the establishment and operation of the hoped-for comprehensive health complexes, and it must be presumed that, unless renewed by Congress, the Act will expire before any extensive benefits are attained. The paucity of results will come from local apathy and not from the lack of sincerity and devotion on the part of the Health Advisory Committee.

GROWTH OF FULL-TIME MEDICAL SCHOOL FACILITIES

During the past 15 years there has been a decided increase in the number of full-time faculty members in United States Medical Schools. According to a recent datagram (March 1966) distributed by the Association of Medical Colleges, the number of full-time faculty members in medical schools in 1950 was 3,933. In 1965 the figure had risen to 15,514, and it is estimated that by 1970 the figure will rise to 24,000, which is a formidable number indeed.

The older generation of physicians will recall that when they were medical students, except for those who taught the basic sciences—that is, anatomy, bacteriology, biochemistry, pathology, pharmacology and physiology—there were only a few full-time men on the faculty. The school which first adopted the full-time plan for medical teachers was Johns Hopkins University. Later the plan was used by the University of Chicago.

There are still some physicians, although they are greatly in the minority, who do not fully subscribe to the use of full-time clinical teachers. They believe that a physician who is in active private practice has something to offer medical students which many full-time men may not have. This objection can be met, in a measure at least, by having men on the teaching staff who have the title of "clinical professor" or some such variant. This title denotes that his major efforts are concerned with private practice.

It is not the purpose of this editorial to debate the pros and cons of the question of a full-time clinical staff. We do wish, however, to emphasize that it is virtually mandatory that the chairmen of major clinical departments (and perhaps also those who are in charge of some of the specialties) be full-time teachers.

Chairman of clinical departments have manifold duties; to name some of them: full-time teachers must have responsibility for patient care; they must also supervise the teaching program, consult with students, foster research, keep up with the recent literature, and attend many local, state and national meetings. If all these obligations are met, obviously, there is not much time for the outside practice of medicine. Parenthetically, it should be recognized that full-time men should be allowed certain consulting privileges. In essence, a core of full-time clinical men are needed in a medical school to conduct a modern clinical teaching program.

The matter of the importance of employing full-time teachers, who serve as chairmen of major clinical departments, was outlined very well many years ago by Dr. William H. Welch of Johns Hopkins University. In a convocation address at the University of Chicago on December 17, 1907, he stated:

> The heads of the principal clinical departments particularly the medical and the surgical, should devote their main energies and time to their hospital work and to teaching and investigating without the necessity of seeking their livelihood in a busy outside practice and without allowing such practice to become their chief professional occupation.

WHY IS A DRIVER LIKE A PRESCRIBER?

We live in an age of therapy with potent drugs, and new weapons are coming to hand every year. These changes are to be welcomed; we cannot put back the clock even if we should wish to do so. The problems now posed by motor cars and drugs are in many ways similar. We must ensure that the price of advance is not too high and that accidents are reduced to a minimum by foresight and care. Both are examined, licensed, and periodically reviewed.

Roads and lines of communication of information are improved. The manufacturers are exhorted to introduce the latest safety devices and tests. However, in the final analysis, most depends on the driver and prescriber.—G. M. Wilson, M. D., in *British Medical Journal.*

GENERAL NEWS

Drs. Hudson and Annis to Speak At 99th Annual Meeting

Two distinguished physicians will join Gov. Hulett C. Smith of West Virginia as honor guests at the 99th Annual Meeting of the West Virginia State Medical Association which will be held at The Greenbrier in White Sulphur Springs, August 25-27.

Charles L. Hudson, M. D.
AMA President

Dr. Carl B. Hall, Chairman of the Program Committee, announced that Dr. Charles L. Hudson of Cleveland, President of the American Medical Association, and Dr. Edward R. Annis of Miami, Florida, a Past President of the AMA, along with Governor Smith, will address general meetings during the convention.

Doctor Hudson was installed as President of the AMA during the Annual Convention in Chicago in June. Doctor Hudson was elected to the Board of Trustees of the AMA in 1961 and served in that capacity until June, 1965, when he was named President Elect in New York City. He practices internal medicine in Cleveland and holds Associate Professorships in Medicine and Preventive Medicine at Western Reserve University.

The AMA President will be the guest speaker before the first session of the House of Delegates, which will begin at 3 P.M. on Wednesday, August 24.

Address by Governor Smith

Governor Smith will deliver an address at the first general scientific session on Thursday morning, August 25. The session will begin at 9 A.M.

Governor Smith, whose home is in Beckley, is a former Chairman of the State Democratic Executive Committee. He served as the State's first Commissioner of Commerce, a position he relinquished to seek the Democratic nomination for Governor in 1964. He was chosen Governor of West Virginia in the General Election of 1964 and took office the following January.

Doctor Annis to Speak Thursday Night

Doctor Annis, one of the medical profession's most articulate voices, will be the principal speaker at a WESPAC meeting on Thursday night beginning at 9:30.

During the past six years, Doctor Annis has traveled extensively throughout the country speaking on behalf of the medical profession. He has represented the AMA at various congressional hearings and has participated in television debates with proponents of socialistic health legislation.

All physicians and their wives and children have been invited by the Program Committee to hear the addresses by Doctors Annis and Hudson and Governor Smith.

Presidential Address

Dr. Seigle W. Parks of Charleston, President of the West Virginia State Medical Association, will deliver his Presidential Address at the second and final session of the House of Delegates on Saturday afternoon, August 27.

The 1966 Program Committee

Dr. Carl B. Hall of Charleston is Chairman of the Program Committee for the 99th Annual Meeting of the West Virginia State Medical Association. Other members are Drs. Halvard Wanger of Shepherdstown, William E. Gilmore of Parkersburg and William G. Klingberg of Morgantown.

Pre-Convention Meetings

Besides the first session of the House of Delegates, there will be another important meeting prior to the formal opening of the meeting on Thursday morning. A meeting of the Council of the State Medical Association will be held at 10 A.M. on Wednesday.

The registration desk will be open in the main floor lobby from 8:30 A.M. to 5 P.M. each day during the convention.

General Scientific Sessions

The three general scientific sessions will be held in Governor's Hall in the West Virginia Wing. Several of the afternoon meetings of sections and affiliated societies also will be held in Governor's Hall and the nearby Mountaineer Room in the new Wing. Other meetings will be held in the Convention Unit.

Exhibits will be housed in the Exhibit Center in the West Virginia Wing just outside Governor's Hall and the Mountaineer Room.

Scientific Motion Pictures

Dr. John J. Mahood of Bluefield is Chairman of the committee arranging the scientific motion picture program during the three-day meeting. Sound motion pictures on scientific subjects will be shown in Governor's Hall on Thursday, Friday and Saturday mornings prior to the opening of each general session.

Formal Opening of Convention

Doctor Hall will call the convention to order at 9 A.M. on Thursday in Governor's Hall. Doctor Parks will deliver the address of welcome, and the first speaker on the program will be Governor Smith. Doctor Hall will then serve as moderator for the scientific portion of the session. The guest speakers and their subjects are:

Robert B. Greenblatt, M. D., Professor and Chairman, Department of Endocrinology, Medical College of Georgia, Augusta. Subject: "The Endocrines."

John R. Haserick, M. D., Head of the Department of Dermatology, The Cleveland Clinic. Subject: "Commonly Missed Dermatological Diagnoses."

James T. Priestley, M. D., Department of Surgery, Mayo Clinic, Rochester, Minnesota. Subject: "Cancer of the Stomach."

Thursday Afternoon Program

Dr. Maynard P. Pride of Morgantown will preside at a meeting of the Resolutions Committee which will be held at 2 P.M. on Thursday.

Luncheon for Past Presidents

A luncheon honoring past presidents of the West Virginia State Medical Association will be held at The Greenbrier on Thursday, August 25, during the 99th Annual Meeting.

Dr. Albert C. Esposito of Huntington, Immediate Past President, will preside. Twenty-four past presidents have been invited to attend the luncheon.

Richard E. Flood, M. D.
President Elect

Doctor Priestley will present papers entitled "Surgical Lesions of the Adrenal Cortex" and "Pheochromocytoma: Diagnosis and Treatment" before a meeting of the Section on Surgery at 2 P.M. Dr. Harry F. Cooper of Beckley will preside.

Drs. Paul F. deGara of New York City and Victor L. Szanton of Derby, Connecticut, will appear as speakers before an open meeting of the West Virginia State Society of Allergy at 2 P.M.

Doctor deGara will present a paper on "Importance of Teamwork Between Allergists, Other Specialists and Practitioners." Doctor Szanton's paper is entitled "Allergy—Serous Otitis Media."

Second General Session
Friday Morning

Dr. Halvard Wanger of Shepherdstown will be moderator for the second general scientific session on Friday Morning, August 26. The speakers and their topics are as follows:

Doris A. Howell, M. D., Professor and Chairman, Department of Pediatrics, Woman's Medical College of Pennsylvania, Philadelphia. Subject: "Care of the Dying Patient."

William M. Deyerle, M. D., Assistant Clinical Professor of Orthopedic Surgery, Medical College of Virginia, Richmond. Subject: "Low Back Pain and Sciatica—Diagnosis and Treatment."

Robert I. Wise, M. D., Magee Professor of Medicine and Head of the Department, Jefferson Medical College, Philadelphia. Subject: "Selection of Antibiotics in the Treatment of Infection."

Edward R. Annis, M. D.
AMA Past President

Friday Afternoon Program

Several sections and societies affiliated with the State Medical Association will conduct scientific and business sessions beginning at 2 P.M. on Friday.

Dr. Arnold J. Brody of White Sulphur Springs will preside at a meeting of the Section on Internal Medicine, which will hear papers by Doctors Haserick and Wise. Doctor Haserick's topic will be "A New Classification of Lupus Erythematosus," while Doctor Wise will talk on "The Recognition and Management of Bacteria of Infective Endocarditis."

Doctor Howell will present a paper on "The Approach to the Anemic Child" at a meeting of the West Virginia Pediatric Society. Dr. Russell V. Lucas, Jr., of Morgantown will preside.

The West Virginia Obstetrical and Gynecological Society will receive a paper by Doctor Greenblatt. Dr. Dwight P. Cruikshank of Parkersburg will preside.

Dr. Worthy W. McKinney of Beckley will preside at a session of the West Virginia Academy of Ophthalmology and Otolaryngology.

Dr. Carl J. Roncaglione of Charleston will preside at a meeting of the Section on Orthopedic Surgery. Doctor Deyerle will present a paper on "Fractures of the Hip—Plate and Multiple Pin Technique with Immediate Weight Bearing End Results."

Dr. D. Franklin Milam of Morgantown will preside at a meeting of the Section on Urology and also will present a paper on "Experiences with Cryosurgery of the Prostate at the WVU Medical Center."

Convention Timetable

The first general scientific session will begin at 9 A.M. on Thursday, August 25. The Friday and Saturday sessions will begin at 9:30 A.M.

The first session of the House of Delegates will be on Wednesday afternoon, August 24, beginning at 3 P.M. The second session will be on Saturday afternoon beginning at 2:30 P.M.

The Exhibit Center will be open from 8:30 A.M. to 3:30 P.M. on Thursday and Friday and from 8:30 A.M. to 1 P.M. on Saturday.

The West Virginia Radiological Society will have a business meeting and film session with Dr. E. Walter Rice of Martinsburg presiding.

The West Virginia Society of Anesthesiologists also will have a business meeting with Dr. N. W. B. Craythorne of Morgantown presiding.

Dr. William J. German, Professor of Surgery at the Yale University School of Medicine in New Haven, Connecticut, will present a paper before the Section on Neurology, Neurosurgery and Psychiatry. His topic will be "Considerations Regarding Treatment of Intracranial Carotid Aneurysm." Dr. W. E. Wilkinson of Beckley will preside.

Meeting at 3 P.M. on Friday will be the West Virginia Chapter, American Society of Internal Medicine, with Dr. A. B. Curry Ellison of Charleston presiding.

Dr. L. J. Pace of Princeton will preside at a meeting of the Committee on Nominations which will be held at 5 P.M.

Third General Session
Saturday Morning

The third and final general scientific session on Saturday morning will be devoted to a symposium on "The Problems of the Adolescent" with several members of the faculty of the West Virginia University School of Medicine participating. Dr. William G. Klingberg, Professor and Chairman of the Department of Pediatrics at the School of Medicine, will give the introduction and serve as moderator for the discussion. The speakers and their subjects will be:

Roland E. Schmidt, M. D., Assistant Professor of Pediatrics. Subject: "Adolescent Growth and Nutrition."

House of Delegates To Meet Twice During Meeting

The first session of the House of Delegates during the Annual Meeting at The Greenbrier will be convened at 3 P.M. on Wednesday, August 24. The second and final session of the House of Delegates will be held at 2:30 P.M. on Saturday, August 27.

Paul Davidson, M. D., Instructor in Medicine. Subject: "Specific Medical Problems of Most Importance to the Adolescent."

Nicholas W. Fugo, M. D., Chairman of the Department of Obstetrics and Gynecology. Subject: "Gynecologic Growth and Problems in the Adolescent."

Robert L. Vosburg, M. D., Chairman of the Department of Psychiatry. Subject: "Emotional Development and Problems of the Adolescent."

There will be a question and answer period following the presentation of formal papers.

Saturday Afternoon Meetings

The West Virginia Association of Pathologists will conduct a business meeting at 1:30 on Saturday afternoon. Dr. J. Evan Sadler of Huntington will preside.

Second Session of the House of Delegates

The second and final session of the House of Delegates will be held on Saturday afternoon beginning at 2:30 P.M. Doctor Parks will preside, and the session will feature Doctor Parks' Presidential Address and the installation of Dr. Richard E. Flood of Weirton as the 100th President of the West Virginia State Medical Association. Other officers for 1966-67 also will be elected and installed.

James C. Bosley of New Creek and Earl H. Eye, Jr., of Deer Run, the recipients of the State Medical Association's 1966 four-year scholarships to the West Virginia University School of Medicine, will be introduced at this session.

A check representing physician contributions to the WVU School of Medicine through the AMA-ERF program will be presented to Dr. Clark K. Sleeth of Morgantown, Dean of the School of Medicine.

Medical School Alumni Parties

The Alumni Associations of two medical schools will hold cocktail parties in connection with the Annual Meeting.

The West Virginia Chapter of the Medical College of Virginia Alumni Association will hold a cocktail party on Friday evening at 6:30 o'clock. Dr. W. Fred Richmond of Beckley is in charge of arrangements.

Another cocktail party will be held on Friday evening at 6:30 o'clock by the University of Virginia Alumni Fund—Medical Division. This is the first year a function has been sponsored at The Greenbrier by the University of Virginia. Dr. L. J. Pace of Princeton is in charge of arrangements.

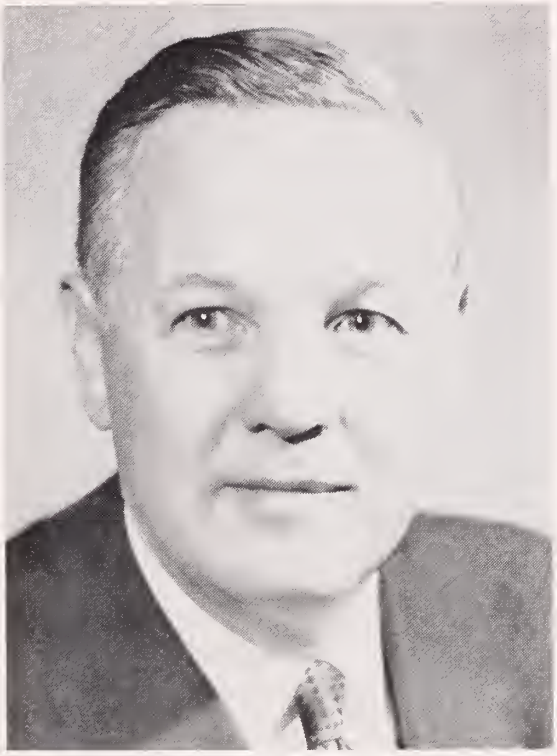
Representatives of both schools have indicated that several administrative officials plan to be in attendance.

Dance on Friday Evening

The Woman's Auxiliary to the West Virginia State Medical Association will sponsor a dance in Chesapeake Hall on Friday evening beginning at 10 P.M.

Cocktail Party on Saturday Evening

A cocktail party and reception honoring the officers of the West Virginia State Medical Association will be held on the Chesapeake Hall Terrace on Saturday evening from 6:30 to 7:30 P.M. All members of the Association and the Auxiliary, their families, representatives of the industrial and scientific exhibits and guests are invited to attend.



Hon. Hulett C. Smith
Governor of West Virginia

Prizes to the winners of the golf and bowling tournaments will be awarded at that time.

Industrial and Scientific Exhibits

Physicians, members of the Auxiliary and guests are invited to visit the more than 50 informative industrial and scientific exhibits which will be located in the Exhibit Center throughout the meeting. The exhibits will be open each day from 8:30 A.M. to 3:30 P.M.

Heavy Registration

The number of reservations for rooms at The Greenbrier during the Annual Meeting has passed the 450 mark. More than 700 persons are expected to be in attendance.

Motion Picture Schedule

Dr. John J. Mahood of Bluefield, Chairman of the motion picture program for the Annual Meeting at The Greenbrier, has announced the schedule of movies, which will be shown in Governor's Hall each morning prior to the general scientific session.

Thursday—"Cushing's Disease."

Friday—"Removal of Intraocular Foreign Bodies" and "Diabetes in Youth."

Saturday—"For Those Who Drink" and "Thrombectomy in Acute Ileo-Femoral Venous Thrombosis."

99th Annual Meeting Will Feature Bowling Tournament

A bowling tournament for physicians and their wives and children will be a feature of the 99th Annual Meeting of the West Virginia State Medical Association.

Dr. John M. Daniel of Beckley is Chairman of the tournament. Doctor Daniel said the tournament would be divided into scratch and handicap divisions for physicians, a scratch division for women and a scratch division for children.

A registration fee of $5.00, payable at the bowling lanes at The Greenbrier, will cover prizes, bowling fees, tax and gratuity. Rental of such equipment as shoes will be extra.

The tournament will be conducted from 3 P.M. to 6 P.M. on Thursday and Friday, August 25-26. Prizes will be awarded to winners at the reception for officers of the State Medical Association on Saturday evening, August 27.

Doctor Daniel announced the following guidelines for the tournament:

1. Those physicians who are members of the American Bowling Congress must use their official ABC averages and they must have a note from their local league secretary confirming their average at the time of the tournament.

2. Those physicians who do not have an ABC average must establish an average by bowling three lines at the Greenbrier lanes. The line charge for this will be in addition to the registration fee.

3. Physician participants may enter the tournament twice—once in the handicap division where the player's handicap is used and once in the scratch division where the handicap is not added to the score. The player must designate which division he is entering before bowling the lines and must bowl twice if he wishes to bowl in both divisions.

4. Two or more players may bowl together and keep their own scores.

5. The value and number of prizes will be determined by the number of entrants.

State Welfare Dept. Names Deputy Commissioner

Mr. Charles F. McDermott, a certified public accountant, has been named Deputy State Welfare Commissioner.

Mr. McDermott, who has been the department's assistant commissioner of finance, fills a position occupied by Mr. L. L. Vincent before Mr. Vincent was appointed State Welfare Commissioner more than one year ago.

A graduate of Morris Harvey College, Mr. McDermott began his career in state government with the Tax Department in 1956. He also has been on the staff of the Legislative Auditor and worked two months on a United Nations fiscal project in the African Republic of Ghana.

New Association Members

Dr. Hugh S. Cook, Jr., The Golden Clinic, Elkins (BRT). Doctor Cook, a native of Donthan, Alabama, was graduated from Wake Forest College and received his M. D. degree in 1952 from the Bowman-Gray School of Medicine. He interned at Piedmont Hospital in Atlanta, Georgia, 1952-53, and served a residency at the Tripler U. S. Army Hospital in Honolulu, Hawaii, 1955-58. He served as a Captain in the Medical Corps of the United States Army and was previously located in Helena, Montana. His specialty is obstetrics and gynecology.

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Dr. Cyril D. Gettliffe, DuPont Plant, Parkersburg (Parkersburg Academy). A native of Johannesburg, South Africa, Doctor Gettliffe received his M. D. degree in 1942 from the University of Witwatersrand in Johannesburg. He served a residency at Charleston General Hospital and was licensed to practice in West Virginia in 1965. He is engaged in industrial medicine.

* * * *

Dr. Robert A. Jenkins, 317 Market Street, Parkersburg (Parkersburg Academy). Doctor Jenkins, a native of Niles, Ohio, was graduated from Kent State University and received his M. D. degree in 1952 from Western Reserve University. He interned at Youngstown Hospital in Youngstown, Ohio, 1952-53, and served residencies at the VA Hospital in Topeka, and Duke University Hospital. He served with the Armed Forces during World War II and formerly served as Chief of the Outpatient Services at the VA Hospital in Topeka. His specialty is psychiatry.

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Dr. Stancil E. D. Johnson, WVU Medical Center, Morgantown (Monongalia). Doctor Johnson, a native of Guthrie, Oklahoma, was graduated from the University of Arkansas and received his M. D. degree in 1959 from the University of Arkansas School of Medicine. He interned at the University of Arkansas Hospital, 1959-60, and served a residency at the Mental Health Institute in Cherokee, Iowa. He is currently serving as an Instructor in Psychiatry at the West Virginia University School of Medicine.

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Dr. Donald P. Stacks, 819 West Virginia Building, Huntington (Cabell). Doctor Stacks, a native of Welch, was graduated from the University of Virginia and received his M. D. degree in 1958 from the University of Virginia School of Medicine. He interned and served a residency at the University of Virginia Hospital. His specialty is thoracic and cardiovascular surgery.

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Dr. James L. Steele, 1901 19th Street, Nitro (Kanawha). Doctor Steele, a native of Welch, was graduated from West Virginia University and attended the two-year WVU School of Medicine. He received his M. D. degree in 1962 from the Medical College of Virginia and interned at Lewis-Calz Hospital in Roanoke, Virginia. He served with the United States Army and was licensed to practice in West Virginia in 1964. He is engaged in general practice.

Among persons attending the Aces and Deuces breakfast on Tuesday, June 28, in connection with the AMA annual meeting were: Dr. and Mrs. Albert C. Esposito of Huntington; Mr. David Weihaupt, AMA Field Representative for West Virginia; Dr. Seigle W. Parks of Charleston; Dr. Richard V. Lynch, Jr., of Clarksburg; Mr. James Imboden of Columbus, Ohio, AMPAC Field Representative for West Virginia; and Dr. Richard E. Flood of Weirton.

IMA Meeting in Pittsburgh

The Fall Scientific Meeting of the Industrial Medical Association of the Pittsburgh-Cleveland Area will be held on September 9 at Mellon Institute in Pittsburgh.

Additional information may be obtained by writing to Dr. E. A. McGovern, Pittsburgh Works Division, Jones & Laughlin Steel Corporation, 2812 East Carson Street, Pittsburgh.

Dr. Seigle W. Parks of Charleston, President of the West Virginia State Medical Association, is Vice President of the Area Association. Directors include Drs. James G. Ralston of Clarksburg and Arthur M. Phillips of Weirton.

Gov. Smith Appoints Physicians To State Boards

Gov. Hulett C. Smith announced the appointment of several West Virginia physicians to state boards and other agencies, effective July 1.

Dr. Maynard P. Pride of Morgantown was named to a five-year term on the Medical Licensing Board, succeeding Dr. George F. Evans, Editor of *The Journal*. In June, Doctor Evans announced his retirement from the Board.

Dr. Richard W. Corbitt of Parkersburg, Chairman of the Commission on Post-Mortem Examinations, was reappointed to a six-year term on the Commission.

Dr. Russel Kessel of Charleston was appointed to a seven-year term on the Advisory Board to the State Board of Health.

Dr. Pat A. Tuckwiller of Charleston was named to a new six-year term on the State Advisory Board to the Department of Welfare.

Drs. Henrietta L. Marquis of Charleston and W. Gene Klingberg of Morgantown were reappointed to three-year terms on the Advisory Committee to the State Commission on Mental Retardation.

Doctor Holroyd Reelected Secretary Of Aces and Deuces

Dr. Frank J. Holroyd of Princeton was reelected to an eighth consecutive term as Secretary-Treasurer of the Aces and Deuces organization at the annual breakfast meeting held at The Palmer House in Chicago on June 28. The meeting was attended by 194 members and guests.

Dr. Leslie A. Moren of Elko, Nevada, was elected President succeeding Dr. James M. Kolb of Clarksville, Arkansas.

Aces and Deuces is a social organization composed of delegates and alternate delegates to the American Medical Association from states which have one or two AMA delegates.

An Aces and Deuces luncheon honoring AMA officers and members of the House of Delegates will be held during the AMA Clinical Convention in Las Vegas, Nevada, in November.

Health Task Force Adds Two Physicians

Gov. Hulett C. Smith has added six members, including two physicians, to his Task Force on Health.

The two new physician members, both members of the West Virginia State Medical Association, are Drs. Daniel Hale of Princeton and F. A. Hamilton, Jr., of Martinsburg.

The Governor's Office said the appointment of the six new members will bring a wider geographic representation to the Task Force and will strengthen committees charged with preparing long-term programs to meet the state's health needs.

The Task Force will make an outline report to Governor Smith next month and will submit a final report in December.

AMA Names Dr. Milford O. Rouse President Elect

Dr. Milford O. Rouse of Dallas, Texas, was named President Elect of the American Medical Association during the 115th Annual AMA Meeting, which was held in Chicago, June 26-30.

Doctor Rouse, Speaker of the AMA House of Delegates for the last three years, was elected by acclamation. He will assume the presidency next June, succeeding Dr. Charles L. Hudson of Cleveland, who took office during the Chicago meeting.

Other New Officers

Dr. Eli S. Jones of Hammond, Indiana, was elected Vice President of the AMA, and Dr. Walter C. Bornemeier of Chicago was named Speaker of the House to succeed Doctor Rouse. The new Vice Speaker, succeeding Doctor Bornemeier, is Dr. Russell B. Roth of Erie, Pennsylvania.

Dr. Homer L. Pearson of Miami, Florida, and Dr. Dwight L. Wilbur of San Francisco were re-elected to the Board of Trustees. New members of the Board are Drs. Burtis E. Montgomery of Harrisburg, Illinois, and Max H. Parrott of Portland, Oregon.

Dr. Kenneth C. Sawyer of Denver, Colorado, was re-elected to the Council on Medical Education. Dr. James W. Haviland of Seattle, Washington, also was elected to the Council.

For the Council on Medical Service, the House re-elected Dr. Charles J. Ashworth of Providence Rhode Island, and elected Drs. Guy A. Owsley of Hartford City, Indiana, and John R. Kernodle of Burlington, North Carolina.

Dr. James M. Kolb, Sr., of Clarksville, Arkansas, was re-elected to the Council on Constitution and Bylaws. Named to the Judicial Council were Dr. Renato J. Azzari of New York City and Dr. George W. Petznick of Cleveland, Ohio.

State Physicians Attend Meeting

West Virginia was represented at the business sessions by Drs. Frank J. Holroyd of Princeton and C. A. Hoffman of Huntington, AMA Delegates.

Also attending the meeting were the following officers of the West Virginia State Medical Association: Dr. Seigle W. Parks of Charleston, President; Dr. Richard E. Flood of Weirton, President Elect; Dr. Richard V. Lynch, Jr., of Clarksburg, Vice President; and Dr. Albert C. Esposito of Huntington, Chairman of the Council.

Summary of Chicago Meeting

The following summary of the AMA meeting was prepared for publication by Dr. F. J. L. Blasingame, Executive Vice President of AMA:

Federal health legislation, physicians' billing procedures, medical ethics, racial discrimination, health manpower and an increase in AMA annual dues were among the major subjects acted upon by the House of Delegates.

The 1966 AMA Distinguished Service Award was voted to Dr. Warren H. Cole of Chicago, Head of the Department of Surgery at the University of Illinois College of Medicine, for his work in cancer research and his many contributions to medical literature.

The Layman's Citation for Distinguished Service was awarded to Danny Thomas, well known entertainer, for his leadership in founding the St. Jude Children's Research Hospital at Memphis, Tennessee.

Final registration for the meeting reached a total of 35,506, including 12,445 physicians and 23,061 guests.

Federal Health Legislation

The House of Delegates received and considered a large number of reports and resolutions dealing with Medicare, the expanded Kerr-Mills program under Title 19 of Public Law 89-97 and other federal laws or programs.

In accepting and commending a Board of Trustees report on Medicare, the House recommended that "the Association give wide dissemination to the information contained therein, particularly its informed discussion of direct billing, the basic purposes of utilization review, the rejection of compensation for service on such committees except in exceptional circumstances, and the proper placement of any onus of responsibility for any failure in the Medicare program."

The Board report ended with the following conclusion:

"During the past year many individuals have represented the American Medical Association and the physicians of the United States by meeting frequently with officials of the Department of Health, Education and Welfare. This degree of cooperation on our part should be viewed as a recognition by responsible citizens of an obligation to obey the law of the land, including this law with which we disagree. Our specific purposes have been to provide expert assistance to the government so that this law could be implemented in a manner most helpful to the beneficiaries while disturbing the practice of medicine to the minimum degree. Despite our best efforts it is apparent that serious problems are inevitable in connection with the implementation of this law and we trust that the physicians and the public will place the blame for such deficiencies squarely where they belong—on the Federal Government.

"We are proud of the role we have assumed and in many instances our efforts have been productive. Proposed forms were simplified; some unnecessary forms eliminated, and a number of our suggestions was incorporated in regulations and procedures. An informative "Reference Guide" for physicians, recently distributed, was prepared with consultation of AMA staff. Numerous other items will continue to receive our most serious study and consideration, and the Board urges and requests that every member exhibit his personal diligence by supplying his local medical society documented evidence of transgressions of the spirit or the letter of the law as it is implemented.

"The Board of Trustees intends to continue to supply advice, guidance, and dissent when necessary to the Government or to other third parties on matters that pertain to the health of the public and the interests of the medical profession."

The House strongly supported the general concept of individual responsibility and endorsed a report from the Council on Medical Service which included the following statement:

"Since the Council believes that the current interest in the doctrine of individual responsibility stems in large part from concern over the matter of assignments under PL 89-97, it hastens to add that, as a matter of American Medical Association policy, the Council on Medical Service recommends reaffirmation of the responsibility of individual physicians for determining how they will govern their professional practices under this law and that physicians should be made acutely aware of the manifest superiorities of direct billing as previously communicated to this House in the Council's Report E (A-66) on 'Recommendations on the Physician's Role in Medicare.' "

Physicians' Billing Procedures

In connection with the Medicare part of Public Law 89-97, the House also adopted three resolutions which recommended that physicians use the direct billing method rather than the assignment procedure. At the same time, the House pointed out that adoption of these resolutions should not be interpreted as contravening the statement approved at the Special Session in October, 1965, which said:

"The American Medical Association opposes any program of dictation, interference or coercion, whether direct or indirect, affecting the freedom of choice of the physician to determine for himself the extent and manner of participation or financial arrangement under which he shall provide medical care to patients under Public Law 89-87."

In considering a resolution on the right to bill patients under Title 19 of the law, the House passed an amendment pointing out that direct billing has been recommended as the billing method of choice under Title 18 by the Board of Trustees and the Council on Medical Service. It then said that since there is a wide latitude available to the states in establishing administrative procedures under Title 19, each state medical association should work early and diligently in its own state so that any plan or law adopted in its state for approval under Title 19 would include authorization for direct billing.

The House also instructed the AMA Advisory Committee to the Department of Health, Education and Welfare to do all in its power to implement the intent of the resolution at the national level.

Hospital-Based Physicians

The House passed two resolutions involving billing and reimbursement principles affecting hospital-based specialists but also of significance to all physicians. The first said:

"The Principles of Medical Ethics declare that a physician shall not dispose of his services to a third party or "lay" organization, and

"Title XVIII of Public Law 89-97 recognizes the principle of the separation of professional and hospital costs for services rendered by hospital-based physicians; and

AMA Delegates Limit Size of House

The AMA House of Delegates adopted an amendment to the By-Laws that would limit the size of the House of Delegates to 250 delegates. The change allows one delegate for every 1,250 members if and when the House reaches 250 members.

Present By-Laws allow one delegate for every 1,000 members.

The adopted amendment also incorporated a resolution introduced by the West Virginia Delegation which asked that no state association should lose a delegate because of the new delegate-member ratio.

Section delegates are not counted as delegates from the states in which they live.

"This principle has been advocated by the AMA, the American College of Radiology, the American College of Pathologists, and many regional organizations, and

"A great number of hospital-based physicians throughout the nation have declared their intention to bill separately for their professional services in keeping with this principle; therefore be it

"Resolved, That, since separate billing by the physician for his professional services is a preferred ethical practice, it shall be deemed unethical for a physician to displace a hospital-based physician who is attempting to practice separate billing when said displacement is primarily designed to circumvent separate billing."

The second resolution expressed regret that publication of Medicare Regulation No. 5 was delayed until June 28, three days before the effective date of Medicare, and said that these regulations do not conform to the intent of Congress as expressed in Section 1801 of the Medicare law. It then declared that:

"The House of Delegates instruct the Board of Trustees and the Executive Vice President to request from the Social Security Administration an extension of date of final adoption of the proposed regulations of not less than 90 days, in order that the American Medical Association and all other interested medical organizations be allowed reasonable time to study, and to submit, to the Social Security Administration data,

Auto Emblem Price Raised

The price of automobile emblems bearing the insignia of the West Virginia State Medical Association has been raised from $3.25 to $5.00 postpaid.

An increase in the supplier's price made the adjustment necessary.

A supply of emblems is kept on hand at all times at the Headquarters Office in Charleston.

views or arguments and pertinent constructive comments and suggestions.

"To preserve the professional independence of medical practice that the Board of Trustees and Officers of the AMA be instructed to immediately inform the membership that Medicare Reg. No. 5 will not apply to physicians (whether hospital-based or not) who

"1. have no financial relationship with a hospital covering medical services to patients

"2. do not accept assignments but bill directly

"*The AMA News* and other appropriate media be used to advise all physicians who are developing contractual relationships with hospitals for professional service that they should delay the finalization of any agreements pending further analysis of the implementing regulations."

Medical Ethics

In acting upon a Board of Trustees recommendation that a physician may participate in the ownership of a pharmacy or regularly dispense drugs, remedies or appliances or provide eyeglasses to his patients *only when approved by his component and constituent medical associations and when it is determined by them to be necessary in the best interests of the patient,* the House approved the following reference committee statement:

"The Principles of Medical Ethics provide: 'Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.' Your reference committee reaffirms the 1963 House of Delegates interpretation of the words 'in the best interest of the patient,' which reads as follows:

" 'It is the opinion of the Judicial Council that this language was adopted to permit both the practicing physician and the local medical societies to evaluate the many factual situations incident to prescribing and dispensing which are bound to arise in the practice of medicine. Under this language the doctor is permitted to exercise his own best judgment when caring for his patient. It is known that there will be situations when it is necessary or desirable for a physician to dispense or supply what he has prescribed. The Principles permit this to be done. On the other hand, this broad language provides a means by which a component medical society can inquire into the facts of a particular practice. The profession thus can act to prevent abuse of discretion and protect patients from exploitation. In essence this language means that a physician in the exercise of sound discretion may dispense 'in the best interest of his patient'; it does not authorize him to dispense solely for his convenience or for the purpose of supplementing his income.'

"The reference committee approves the goals sought by the Board's report, but disapproves its specific recommendations. It notes that mechanisms presently exist for processing charges of deviation from the foregoing ethic and urges that these mechanisms be made vitally active at local level. When charges of deviation develop, complaints should be made to the local society and vigorously processed by the appropriate committee of that society. If they are not resolved thereby, the complaints should then be carried to the state constituent association. The prudent physician will always seek the guidance of his local medical society in situations relating to ethical conduct."

Discrimination

The House received six resolutions dealing with the subject of discrimination against some applicants for membership in component medical societies. It called attention to the strong position taken by the House in 1964 but pointed out that it is difficult to follow the 1964 directive because there is now no mechanism at the national level whereby a rejected applicant for membership at county or state level may obtain a hearing in order to right an alleged wrongful discrimination.

In lieu of the six resolutions, the House adopted a substitute resolution which directed the Council on Constitution and Bylaws to prepare such changes in the Constitution and Bylaws "as may be necessary to permit the Judicial Council to receive and act upon appeals filed by applicants who allege that they have been unfairly denied membership in a local and/or state society." The House asked the Council to report its recommendations at the 1966 Clinical Convention.

Health Manpower

On the subject of health manpower the House received reports from the Board of Trustees, Council on Medical Education and Council on Medical Service and also one resolution. In general, all of them urged the AMA to assume leadership and mobilize its efforts to meet present and future shortages in health manpower.

The House approved the Board report, announcing appointment of a Committee on Health Manpower, and adopted the resolution. The two Council reports were referred to the new Board committee.

AMA Dues Increase

By a vote of 168 to 46, the House approved an increase in AMA annual dues from $45 to $70, effective January 1, 1967, thus confirming a Board of Trustees recommendation which was given initial approval at the 1965 Clinical Convention.

The House, in approving the dues increase, accepted a reference committee statement which said:

"It is quite apparent that the programs necessary to serve the needs of the members of the Association cannot be conducted effectively without adequate financing and it is equally apparent that such adequate financing is impossible without the dues increase requested by the Board of Trustees."

Other Actions

In considering 106 resolutions, 38 Board reports and at least 20 additional reports from councils and other groups, the House of Delegates also:

Reaffirmed its opposition to the compulsory assessment of hospital staff members in order to raise funds for hospital construction;

Reconsidered its action in defining usual, customary and reasonable fees and referred the matter back to the Council on Medical Service for further study;

Commended the American Medical Association Education and Research Foundation for its accomplishments during the past four years and gave a standing vote of gratitude to Dr. Raymond M. McKeown, AMA-ERF president since 1962;

Strongly endorsed the AMA Volunteer Physicians for Vietnam program and urged the entire profession to support it by word and deed;

Adopted a resolution urging constituent medical associations to oppose, as detrimental to the public interest, any proposed legislation that would authorize optometrists to engage in the diagnosis or treatment of disease or injury of the eye;

Reaffirmed its opposition to the compulsory regulation of any single method, such as the use of generic terms, of the prescribing of drugs;

Adopted a humorous resolution and an equally humerous reference committee report which requested that "in the future full air-conditioning be considered as a prerequisite in the selection of the headquarters hotel for the annual AMA Convention in those cities where the psychophysiological effects of heat may interfere with effective delegatemanship";

Received as information a comprehensive report on the Relation of Medicine and Osteopathy, which contains much material pertinent to future policy considerations, and also approved in principle a recommendation that doctors of osteopathy be commissioned in the Armed Forces Medical Services;

Agreed with a report recommending that the core curriculum plan for continuing medical education be not approved in its present form, that no further core curricula be developed at this time, and that various methods of continuing medical education be studied under the auspices of the Council on Postgraduate Programs;

Expressed its opposition to the Hart bill, S. 2568, and all similar legislation; and

Approved Board reports on Exercise and Physical Fitness, encouraging state and local medical societies to support the promotion of fitness programs, and on Venereal Disease Control, emphasizing the continued need for all physicians to report all cases that come to their attention.

Presidential Addresses

Calling upon the medical profession for strength and unity in resisting the present socialist trend in this country, Dr. James Z. Appel of Lancaster, Pennsylvania, retiring AMA president, told the Sunday opening session that physicians "must participate in the ranks of both political parties and have a voice in the determination of party policy and the writing of party platforms."

Doctor Hudson, in his inaugural address Tuesday, declared that "we shall need all of our intellectual and scientific resources to cope with the new economics of medicine" and to prevent the extension of the Medicare program, without demonstrated need, toward a national health service.

Speaking at the final session of the House on Thursday, Doctor Hudson said that "a demonstration of our ability to perform must clearly indicate not only our competency in the field of medicine, but also our ability to react to a new kind of government thrust into health care." He warned that the real threat to our system of medicine is not in the details of Medicare implementation but in the expansion of the principle of social insurance.

Association Donates $4,000 To Student Fund

The West Virginia State Medical Association has donated another $4,000 to a revolving loan fund at the West Virginia University School of Medicine.

At a meeting in Morgantown last April, the Association's Committee on Scholarships authorized the donation. The Committee is headed by Dr. J. P. McMullen of Wellsburg.

In 1963, the Committee set up the fund within the framework of the West Virginia University Foundation and as a division of the Charles Lively Memorial Scholarship and Loan Fund. This is in addition to the two $4,000 scholarships awarded annually by the Association to students enrolled in the first-year class of the School of Medicine.

The loans from the loan fund are made under the following conditions:

(1) Loans shall be made only to those who have been determined by the Registrar of the University to be *bona fide* residents of West Virginia.

(2) Eligibility is restricted to members in good academic standing of the second, third and fourth year classes of the School of Medicine of West Virginia University.

(3) The applicant must demonstrate need to the satisfaction of the School of Medicine Faculty Committee on Student Welfare.

(4) The maximum loan available from this source to any student during one academic year shall be $400.

(5) Each loan shall bear interest at the rate of four per cent per annum beginning one year after receipt of the M. D. degree or one year after leaving medical school for any cause.

(6) Full repayment will be expected by the end of the third year following receipt of the M. D. degree or following departure from medical school for any cause.

(7) The Executive Secretary of the West Virginia State Medical Association shall receive notification from the Chairman of the Medical School Committee on Student Welfare of the name of each recipient of a loan, and the amount of the loan.

(8) Each student receiving a loan from this fund shall be informed by the Chairman of the Medical School Committee on Student Welfare of the source of the funds from which the loan was made.

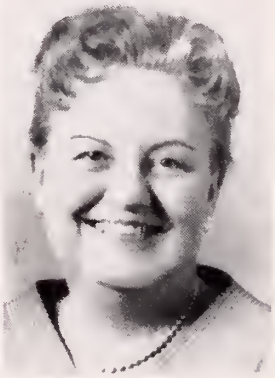
Need a New Auto Emblem?

A supply of auto emblems, bearing the insignia of the West Virginia State Medical Association, is kept on hand at all times at the headquarters offices in Charleston. The price of each emblem is $5.00 postpaid.

Mrs. Asher Yaguda To Address State Auxiliary Meeting

Mrs. Asher Yaguda of Newark, New Jersey, President of the Woman's Auxiliary to the American Medical Association, will be the keynote speaker for the 42nd Annual Meeting of the Woman's Auxiliary to the West Virginia State Medical Association.

Mrs. Asher Yaguda



Mrs. William G. Thuss

The meeting will be held at The Greenbrier in White Sulphur Springs, August 25-27, in conjunction with the 99th Annual Meeting of the State Medical Association.

Other honor guests will be Mrs. William G. Thuss of Birmingham, Alabama, President of the Woman's Auxiliary to the Southern Medical Association, and Mr. James E. Swan of Washington, D. C., Secretary of the National Electrical Contractors Association. Mr. Swan is the brother of Mrs. Wilson P. Smith of Huntington, President of the State Auxiliary.

Mrs. Smith will preside at the three-day meeting. More than 200 physicians' wives are expected to register for the sessions.

Pre-Convention Meetings

A pre-convention meeting of the Executive Board will be held at 4 P.M. on Wednesday, August 24, the day preceding the formal opening of the convention.

Members of the Auxiliary are cordially invited to attend the first session of the Association's House of Delegates earlier that afternoon. Dr. Charles L. Hudson of Cleveland, President of the American Medical Association, will be the guest speaker.

Address by Governor Smith

Members of the Auxiliary also are urged to attend the formal opening of the Association's Annual Meeting on Thursday morning at 9 A.M. Gov. Hulett C. Smith will present an address.

Following the Governor's appearance, members of the Auxiliary will open their meeting in the Fillmore and Van Buren Rooms at The Greenbrier.

First Business Session

The Auxiliary's general business sessions will be held on Thursday and Friday mornings. Afternoons will be free for committee meetings and recreation.

Mrs. Smith will preside at the formal opening Thursday morning, and Mrs. Charles E. Andrews of Morgantown will give the pledge of loyalty.

The business of the first session will include recommendations of the Board, reports of the nominating and other committees and the election of the 1967 Nominating Committee. County presidents will be presented by the four state vice presidents.

Mrs. Pat A. Tuckwiller will report on the June convention of the Woman's Auxiliary to the AMA.

Keynote Address by Mrs. Yaguda

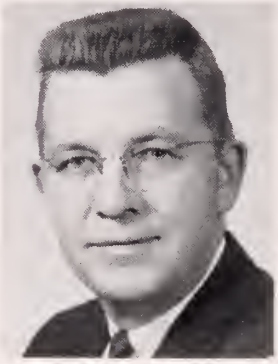
Mrs. Yaguda will give the keynote address at the first session.

An active member of the Auxiliary for 25 years, Mrs. Yaguda has held many important offices, including the presidency of the Essex County, New Jersey, and the New Jersey auxiliaries. On the national level, she has been First Vice President, Director, Chairman of the Structure Review Committee, Eastern Regional Chairman of Community Service, Chairman of the Public Relations Committee, and Chairman of the Homemaker Service Manual Committee.

She wrote the "Homemaker Guide," which the Auxiliary published in 1962 and headed the committee which produced the second "Guide" in 1963.

A native of Westfield, New Jersey, Mrs. Yaguda is a graduate of the Yonkers, New York, Hospital School of Nursing. She and Doctor Yaguda, a pathologist, have one daughter and two grandchildren.

In addition to her Auxiliary activities, Mrs. Yaguda has been very active in community and state affairs.



James E. Swan

Mrs. Hu C. Myers

She has served as an officer in her county Republican Women's Club and the League of Women Voters.

She has been chairman of the Essex County Welfare Board; served at national conferences on Chronic Illness and Homemaker Service; served as chairman of the New Jersey Health Committee, White House Conference on Children and Youth; and as chairman of the New Jersey Health Committee, White House Conference on Aging.

In recognition of her many services to her city, county and state, Mrs. Yaguda was named "Woman of the Year, 1959-60" by the Essex County Council of Business and Professional Women's Clubs. She has received many citations from various other groups.

Address by Dr. Edward R. Annis

Auxiliary members and guests are cordially invited to hear an address by Dr. Edward R. Annis of Miami, Florida, a Past President of the American Medical

Association. Doctor Annis will speak at a WESPAC meeting on Thursday evening beginning at 9:30.

Doctor Annis also will address the Auxiliary at its business session on Friday morning.

Election of Officers

The annual Past President's Breakfast will be held on Friday at 8 A.M., with Mrs. George A. Curry of Morgantown, Immediate Past President, presiding.

The second general session will begin at 9:30 A.M. on Friday. Following a report from the Nominating Committee, new officers will be elected. Mrs. Yaguda will officiate at the installation of officers.

The presentation of the President's pin and gavel will be made by Mrs. Smith to Mrs. Hu C. Myers of Philippi, the incoming President. Mrs. Curry will present the Past President's pin to Mrs. Smith.

Following the installation ceremony, Mrs. Myers will make her inaugural address.

Address by Mr. James E. Swan

Mr. James E. Swan of Washington, D. C., Secretary of the National Electrical Contractors Association, will be the guest speaker Friday morning. His topic will be: "So You Married a Doctor."

Mr. Swan attended the Huntington School of Business and joined the NCEA in 1950, when he was appointed manager of the West Virginia-Ohio Valley Chapter of NECA. He served in that capacity until August, 1957, when he was appointed Executive Director of the Ohio Valley Builders Exchange in Wheeling.

He became Director of Labor Relations for NECA in 1960 and later was elected to his present position.

Friday Afternoon Program

The Auxiliary will conduct its Bridge Party and its bowling and golf tournaments on Friday afternoon beginning at 1 P.M. Members are encouraged to visit the Exhibit Center, which will be open until 3:30 P.M. on Thursday and Friday afternoons.

Dixieland Ball on Friday Evening

The Cabell County Medical Society will be host for a Dixieland Ball which will be held in Chesapeake Hall on Friday from 10 P.M. to 1 A.M.

Post-Convention Conference

Mrs. Myers, the new President, will preside at a Post-Convention Conference and Board meeting, which will be held at 10 A.M. on Saturday.

Second Session of House of Delegates

The second and final session of the Association's House of Delegates will be held on Saturday afternoon at 2:30, and members of the Auxiliary are invited to attend. The session will feature the Presidential Address of Dr. Seigle W. Parks of Charleston, President of the State Medical Association, and the installation of Dr. Richard E. Flood of Weirton as the 100th President. Other new officers also will be installed.

A cocktail party and reception honoring the officers of the State Medical Association will be held on the Chesapeake Hall Terrace from 6:30 to 7:30 P.M. on Saturday. All members of the Auxiliary, State Medical Association, exhibitors and guests are invited to attend.

Mrs. Wilson P. Smith
President

Convention Committee

Mrs. Frank M. Peck and Mrs. Ronald E. Crissey, both of Huntington, are Co-Chairmen of the convention. They were appointed by the President, Mrs. Smith.

Mrs. Ritter Named President Elect Of AMA Auxiliary

Mrs. Karl F. Ritter of Lima, Ohio, was named President Elect of the Woman's Auxiliary to the American Medical Association during the Auxiliary's meeting in Chicago in June.

She will be installed as President at the 1967 convention in Atlantic City to succeed Mrs. Asher Yaguda of Newark, New Jersey, who took office during the Chicago meeting.

Mrs. Ritter previously served as Treasurer, Finance Chairman and AMA-ERF Committee Chairman. She was named Lima's "Woman of the Year" in 1951.

No Auxiliary Registration Fee

No registration fee will be assessed against either members or guests in connection with the 42nd Annual Meeting of the Woman's Auxiliary to the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 25-27, 1966.

Venereal Disease Declines In Nation

State Health Director N. H. Dyer reported on a variety of subjects in June issues of the "State of the State's Health."

Doctor Dyer was optimistic about venereal disease, noting a national decline. He said that we are fast reaching the point we had achieved 10 years ago when we thought we had the problem solved.

"What we managed to do was eradicate the venereal disease program, not the disease," Doctor Dyer said. "We can not afford to let this happen again. We have the tools necessary to eradicate syphilis today—we had them in 1957. If we are to totally eradicate syphilis today, we must continue to increase our vigilance for a disease that presents a threat to our nation and our state."

Doctor Dyer noted that venereal diseases infect one million Americans a year—about 3,000 a day, or almost two a minute.

The State Health Director announced an agreement between the State Health Department and the 14 Soil Conservation Districts in West Virginia. Such an understanding is the first of its kind in the United States, and, according to Doctor Dyer, may become a landmark in public health and conservation history.

He explained that the agreement was reached because of overlapping areas of interest in the two fields. He said that both are intimately involved with water and have a great stake in its abundance as well as its quality. He noted that their joint efforts can be especially helpful in the building of recreational facilities, sewage stabilization ponds for sewage disposal purposes, and farm ponds for domestic water supplies. Doctor Dyer stated that expensive and needless duplication of elaborate facilities and services can be avoided and the effort to protect the public made more effective through the combined effort of these governmental agencies.

In another issue of the "State of the State's Health," Doctor Dyer noted that a definite need for comprehensive instruction in the technique of immediate emergency care exists in West Virginia and pointed to the training sessions set up by the State Health Department to help raise the level of competency of persons involved in emergency care.

He mentioned that a Charleston Session is scheduled for August 31 and September 1. Other regional sites selected for later scheduling include Beckley, Buckhannon, Huntington, Parkersburg, Romney, and Wheeling.

Doctor Dyer issued a warning on food poisoning for, he said, "it is during this season that most outbreaks occur." He noted that most cases of foodborne illness in the United States are preventable but continue to occur because people preparing and serving food fail to apply known food protection measures.

Doctor Dyer called attention to three food poisonings prevalent during this season of the year—staphylococcus, botulism, and salmonellosis.

He said that it would be impossible to estimate the number of individual cases of food poisoning in our state that occur each year for fatalities are rare and few illnesses are reported. However, he noted, it has been estimated that more than one million people in the nation are affected each year by foodborne illness.

Doctor Dyer said that proper precaution on the part of food establishments, institutions, and housewives could eliminate this health problem.

No Convention Registration Fee

No registration fee will be assessed against either members or guests in connection with the 99th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 25-27, 1966.

Doctor Esposito To Present Paper At Oph. and Otol. Meeting

Dr. Albert C. Esposito of Huntington will be among the speakers at the Annual Meeting of the American Academy of Ophthalmology and Otolaryngology which will be held at the Palmer House in Chicago, October 16-21.

Doctor Esposito, a Past President of the West Virginia State Medical Association, will present an instructional course on "General Anesthesia and Ocular Surgery."

The course is listed as covering the use of general anesthesia in cataract and other ocular surgical procedures, plus the changes in ocular surgical technique that are recommended when using these agents.

Doctor Esposito currently is serving as a Secretary of the American Association of Ophthalmology and he is a Past President of the West Virginia Academy of Ophthalmology and Otolaryngology.

Health Insurance Institute Announces Booklet

The Health Insurance Institute has announced publication of the eighth annual edition of its booklet, "A List of Current Health Insurance Books."

Two new sections in the 48-page booklet list a variety of statistical reference sources, and background studies on Medicare.

Sixteen new titles have been added to the booklet, and 17 older titles have been deleted. The new edition lists a total of 195 books, 29 periodicals, and 34 organizations dealing with the financing of health care.

The booklet is divided into 12 sections. The chapter headings include General Studies on Health Insurance, Textbooks on Health Insurance, Careers, For the Consumer, Family Money Management, Background Studies, and Other Insurance Booklists.

The 1966 booklet, which lists double the number of books in the first edition (1959), is distributed among 4,000 editors, economists, teachers, librarians, writers, insurance men, and medical, hospital and allied health care people. It serves as a reference guide on current writings on all aspects of health insurance.

The Institute said single copies of the booklet are available to the general public without charge.

Nominating Committee To Meet On Friday, August 26

The Committee on Nominations of the State Medical Association will meet at 5 P.M. on Friday, August 26, during the Annual Meeting at The Greenbrier.

The Committee will consider and recommend to the House of Delegates prior to the election of officers, at its final session, nominees for the offices of President Elect, Vice President, Treasurer, and the American Medical Association Delegate and Alternate.

Dr. L. J. Pace of Princeton will serve as Chairman and the other members of the Committee are the following senior Councilors in point of service from each councilor district: Dr. Joseph L. Curry of Wheeling, Dr. Charles L. Leonard of Elkins, Dr. Andrew J. Weaver of Clarksburg, Dr. Richard W. Corbitt of Parkersburg, Dr. Buford McNeer of Hinton and Dr. William B. Rossman of Charleston.

The By-Laws also specify that nominations may be made from the floor for the various offices.

Division of Rehabilitation Lists Staff Changes

Mr. Earl W. Wolfe of Charleston has been named Acting Director of the West Virginia Division of Vocational Rehabilitation.

Mr. Wolfe, a former Glenville resident who had been serving as Executive Assistant Director, succeeded Mr. F. Ray Power, who reached mandatory retirement age.

Several other top level changes in the Division were announced. Dr. Everett H. Starcher was named Medical Director of the State Rehabilitation Center in Institute, succeeding Dr. Kenneth L. Clark. Doctor Starcher moved from Logan, where he had practiced medicine for a number of years, to Ripley.

Mr. William G. Winchell was promoted from Administrator of the Center to Assistant Director for Workshops and Rehabilitation Facility. Mr. Winchell was succeeded as Administrator by Mr. William R. Phelps, formerly Assistant Administrator.

Mrs. Thomas L. Harris Receives Honorary Degree

Mrs. Elizabeth Harris, wife of Dr. Thomas L. Harris of Parkersburg, was presented with an honorary Doctor of Humanities degree at Bethany College last Spring.

Mrs. Harris was cited for her interest in municipal planning, the training of nurses and doctors, Girl and Boy Scouts, art, music and education.

Dr. Robert R. Brown of Romney Defends Golf Title

Dr. Robert R. Brown of Romney will be aiming for permanent possession of the trophy when he defends his championship in the Medical Golf Tournament, which will be held in connection with the 99th Annual Meeting of the West Virginia State Medical Association, August 25-27.

Doctor Brown shot a 69 last year to win his second tournament and the second leg toward retiring the beautiful trophy sponsored by the Hospital and Physicians Supply Company of Charleston. A physician who wins the tournament three times wins permanent possession of the trophy.

Also eligible to retire the trophy is Dr. Joseph T. Mallamo of Fairmont, who has won the tournament seven times in all. Last year, he finished as runner-up to Doctor Brown with a 73. Doctor Brown previously won the tournament in 1963.

Other low gross scorers last year were Dr. Jack C. Morgan of Fairmont, 78; Dr. Russell V. Lucas, Jr., of Morgantown, 79; and Drs. Jack Leckie of Huntington, George H. Pierson of Clendenin and Robert A. Crawford, Jr., of Charleston, each with 82.

Dr. Joseph A. Smith of Dunbar, Chairman of the Golf Committee, said that physicians participating in the tournament will pay an entrance fee of $5 payable at the time they register to play in the tournament. There will be several prizes in addition to the championship trophy.

Physicians may engage in tournament play both mornings and afternoons during the three-day meeting. Participants are to inform the starter when they begin their official tournament round. All tournament play must be completed by 4 P.M. on Saturday, August 27.

Dr. Vernon L. Dyer Named Honorary Citizen

Dr. Vernon L. Dyer of Petersburg has been named an honorary citizen of Hardy County for his work in the Lions Club sight conservation program.

Doctor Dyer was cited at a Moorefield Lions Club meeting for his 28 years of service to the program. Doctor Dyer implemented locally the program which provides free eye examinations for indigent youngsters.

20 Postgraduate Courses Set by ACP

The American College of Physicians has scheduled 20 postgraduate courses for 1966-67.

The first course of the season, "Advances in Cutaneous Medicine," will be presented in Rochester, Minnesota, September 28 through October 1.

Fees for each of the 20 courses are $60 for members of the ACP and $100 for nonmembers.

Registration forms and other information may be obtained by writing to Dr. Edward Rosenow, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

House of Delegates To Take Action On Constitutional Amendments

Several amendments to the Constitution of the West Virginia State Medical Association, offered at the 98th Annual Meeting in White Sulphur Springs, August 26-28, 1965, will be acted upon finally by the House of Delegates at the 99th Annual Meeting at The Greenbrier, August 25-27, 1966.

The proposed amendments follow:

Article V

Sec. 1. Amend the section by deleting sub-section. (2) and inserting in lieu thereof "all past presidents of the Association; and,". (The effect of this amendment would be to make all past presidents life-time members of the House of Delegates. Past presidents currently are members of the House for a period of 10 years following their tenure of office).

Article VIII

Sec. 2. Delete the entire section and insert in lieu thereof the following: "The place and dates for each annual meeting of the Association shall be selected by the Council." (Under the present Constitution, the place for the annual meeting is selected by the House of Delegates and the dates are selected by the Council).

Article IX

Sec. 2. Amend line 1 by inserting after the word, "Councilors," the words, "and the president." (Note: The president is not elected but is installed into office from that of the president elect).

Sec. 4. Amend line 5 by deleting the word "president," and inserting in lieu thereof the words, "president elect." (Note: If retiring president cannot be eligible for future election as president or vice president, neither should a past president be eligible for election as president elect.

Four State Physicians Named To ASIM Committees

Four West Virginia internists have been given committee assignments by the American Society of Internal Medicine.

The physicians and their assignments are:

Dr. A. B. Curry Ellison of Charleston, Labor-Management Committee; Dr. George F. Evans of Clarksburg, Committee on By-Laws; Dr. Edmund B. Flink of Morgantown, Subcommittee on Academic Membership Committee; and Dr. Robert U. Drinkard of Wheeling, Committee on the Pharmaceutical Industry.

10 Hours AAGP Credit

The 99th Annual Meeting of the West Virginia State Medical Association has been authorized as acceptable for 10 hours credit by the American Academy of General Practice.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1966

Aug. 25-27—W. Va. State Medical Assn., White Sulphur Springs.
Aug. 29-Sept. 1—Am. Hosp. Assn., Chicago.
Sept. 8-10—Am. Assn. of Ob.-Gyn., Hot Springs, Va.
Sept. 9—Maryland Medical, Ocean City.
Sept. 16-24—Am. Soc. of Clinical Path., Washington.
Sept. 17-23—Col. of Am. Pathologists, Chicago.
Sept. 20-22—Kentucky Medical, Louisville.
Sept. 23-24—W. Va. Heart Assn., Morgantown.
Sept. 23-Oct. 1—Am. Soc. of Clinical Pathologists, Chicago.
Sept. 27-28—AMA Cong. on Occupational Health, Portland, Ore.
Sept. 30-Oct. 2—W. Va. Div., Am. Cancer Soc., Cacapon State Park.
Oct. 1-5—Am. Soc. of Anesthesiologists, Philadelphia.
Oct. 6—Rural Health Conf., Jackson's Mill.
Oct. 7-8—AMA Cong. on Medical Quackery, Chicago.
Oct. 10-13—AAGP, Boston.
Oct. 10-14—ACS, San Francisco.
Oct. 11-14—Pennsylvania Medical, Pittsburgh.
Oct. 13-15—Assn. of Am. Phy. & Surg., Disneyland, Calif.
Oct. 15—Cabell County Symposium, Huntington.
Oct. 15-16—Am. Assn. of Oph., Chicago.
Oct. 16-21—Am. Acad. of Oph. & Otol., Chicago.
Oct. 21-25—Am. Heart Assn., New York.
Oct. 22-27—Am. Acad. of Pediatrics, Chicago.
Oct. 23-26—Am. Col. of Gastroenterology, Philadelphia.
Oct. 28-30—Potomac-Shenandoah Valley PG Inst., Martinsburg.
Oct. 31-Nov. 4—Am. Assn. of Public Health Physicians, San Francisco.
Nov. 6-9—Med. Soc. of Virginia, Williamsburg.
Nov. 14-17—Southern Med. Assn., Washington.
Nov. 15-20—Am. Medical Womens Assn., Washington.
Nov. 26-27—Am. Col. of Chest Physicians, Las Vegas.
Nov. 27-30—AMA Clinical Convention, Las Vegas.
Nov. 27—Nat. Conf. on the Med. Aspects of Sports, Las Vegas.
Nov. 29-Dec. 1—Am. Acad. for Cerebral Palsy, Biloxi-Gulfport, Miss.
Dec. 2-3—Am. Rheumatism Assn., Cincinnati.
Dec. 3-6—Am. Acad. for Cerebral Palsy, New Orleans.
Dec. 3-8—Am. Acad. of Dermatology, Bal Harbour, Fla.
Dec. 4-7—Am. Soc. of Hematology, New Orleans.
Dec. 6-8—Southern Surgical Assn., Boca Raton, Fla.

1967

Jan. 14-19—Am. Acad. of Orthopaedic Surgeons, San Francisco.
Jan. 28-Feb. 1—Am. Acad. of Allergy, Phoenix.
Feb. 14-19—Am. Col. of Cardiology, Washington.
March 10-11—AMA Conf. on Rural Health, Charlotte. N. C.
March 9-11—AMA-ABA National Medicolegal Symposium, Miami Beach.
March 19-24—Southeastern Surgical Cong., Bal Harbour, Fla.
April 3-5—Am. Acad. of Ped., San Francisco.
April 7-9—Am. Soc. of Int. Med., San Francisco.
April 10-14—Am. Col. of Physicians, San Francisco.
April 16-20—Am. Col. of Ob. & Gyn., Philadelphia.
April 23-26—W. Va. Acad. of Oph. and Otol., White Sulphur Springs.
April 30-May 2—W. Va. Chapter, AAGP, Huntington.

Frankly, most antihypertensives are pretty good if you give an adequate dose. I'm looking for one with a simple regimen so that mix-ups in doses and therefore the chance of side effects are minimized.

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1 tablet daily brings pressure down

Advantage: Both components of Regroton are long-acting.
Average dosage: One tablet daily with breakfast.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: Discontinue 2 weeks before general anesthesia, 1 week before electroshock therapy, and if depression or peptic ulcer occurs. With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.
Precautions: Reduce dosage of concomitant antihypertensive agents by one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
Side effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.
Availability: Bottles of 100 and 1000 tablets.

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CONVENTION PROGRAM

99th Annual Meeting

of the

West Virginia State Medical Association

THE GREENBRIER, WHITE SULPHUR SPRINGS

August 25-27, 1966

WEDNESDAY MORNING

August 24

(Eastern Daylight Time)

9:00-5:00—Registration, Main Floor Lobby.

10:00—Pre-Convention Meeting of the Council. Albert C. Esposito, M. D., *presiding*. (Lee Room, Virginia Wing).

WEDNESDAY AFTERNOON

3:00—First Session of the House of Delegates. Seigle W. Parks, M. D., *presiding*. (Chesapeake Hall).

Invocation—Carl B. Hall, M. D.

Address: Charles L. Hudson, M. D., President, American Medical Association.

Business Meeting.

THURSDAY MORNING

August 25

8:00—Motion Picture. John J. Mahood, M. D., *in charge*. (Governor's Hall). "Cushing's Disease."

8:30-5:00—Registration, Main Floor Lobby.

Opening Exercises

(Governor's Hall)

9:00—Call to Order—Carl B. Hall, M. D., Chairman, Program Committee.

Invocation—The Rev. Douglas N. Shepherd, Emmanuel Methodist Church, White Sulphur Springs.

Address of Welcome—Seigle W. Parks, M. D., President, West Virginia State Medical Association.

Address: Hon. Hulett C. Smith, Governor of the State of West Virginia.

First General Session

Moderator: Carl B. Hall, M. D.

9:45—Robert B. Greenblatt, M. D., Professor and Chairman, Department of Endocrinology, Medical College of Georgia, Augusta. Subject: "The Endocrines."

10:30—John R. Haserick, M. D., Head of the Department of Dermatology, The Cleveland Clinic. Subject: "Commonly Missed Dermatological Diagnoses."

11:15—Recess for Visiting Exhibits.

11:45—James T. Priestley, M. D., Department of Surgery, Mayo Clinic, Rochester, Minnesota. Subject: "Cancer of the Stomach."

12:30—Recess for Lunch and Visiting Exhibits.

12:30—Luncheon Honoring Past Presidents of the West Virginia State Medical Association. Albert C. Esposito, M. D., *presiding* (Tyler Room).

THURSDAY AFTERNOON

2:00—Resolutions Committee. Maynard P. Pride, M. D., *presiding*. (West Virginia Room).

2:00—Section on Surgery. Harry F. Cooper, M. D., *presiding*. (Mountaineer Room).

Guest Speaker: James T. Priestley, M. D., Rochester, Minnesota. Subjects: "Surgical Lesions of the Adrenal Cortex," and "Pheochromocytoma: Diagnosis and Treatment."

2:00—Open Meeting, West Virginia State Society of Allergy. Marshall J. Carper, M. D., *presiding*. (Governor's Hall).

Moderator: Merle S. Scherr, M. D.

Guest Speakers: Paul F. deGara, M. D., Clinical Associate Professor of Pediatric-Allergy and Chief of the Pediatric Allergy Clinic at the New York Hospital, Cornell Medical Center. Subject: "Importance of Teamwork Between Allergists, Other Specialists and Practitioners."

Victor L. Szanton, M. D. Attending Pediatric Allergist at Griffin Hospital in Derby, Connecticut. Subject: "Allergy—Serous Otitis Media."

THURSDAY EVENING

9:30—WESPAC Meeting. Speaker: Edward R. Annis, M. D., Past President of the American Medical Association. (Chesapeake Hall).

FRIDAY MORNING

August 26

8:00—Motion Pictures. John J. Mahood, M. D., *in charge*. (Governor's Hall). "Removal of Intraocular Foreign Bodies," and "Diabetes in Youth."

8:30-5:00—Registration, Main Floor Lobby.

Second General Session

Moderator: Halvard Wanger, M. D.

9:30—Doris A. Howell, M. D., Professor and Chairman, Department of Pediatrics, Woman's Medical College of Pennsylvania, Philadelphia. Subject: "Care of the Dying Patient."

10:15—William M. Deyerle, M. D., Assistant Clinical Professor of Orthopedic Surgery, Medical College of Virginia, Richmond. Subject: "Low Back Pain and Sciatica—Diagnosis and Treatment."

11:00—Recess for Visiting Exhibits.

11:30—Robert I. Wise, M. D., Magee Professor of Medicine and Head of the Department, Jefferson Medical College, Philadelphia. Subject: Selection of Antibiotics in the Treatment of Infection."

12:15—Recess for Lunch and Visiting Exhibits.

FRIDAY AFTERNOON

2:00—Section on Internal Medicine. Arnold J. Brody, M. D., *presiding*. (Governor's Hall).

Guest Speakers: John R. Haserick, M. D., Cleveland. Subject: "A New Classification of Lupus Erythematosus."

Robert I. Wise, M. D., Philadelphia. Subject: "The Recognition and Management of Bacteria of Infective Endocarditis."

Business Meeting.

2:00—West Virginia Pediatric Society. Russell V. Lucas, Jr., M. D., *presiding*. (Tyler Room).

Guest Speaker: Doris A. Howell, M. D., Philadelphia. Subject: "The Approach to the Anemic Child."

2:00—W. Va. Obstetrical and Gynecological Society. Dwight P. Cruikshank, M. D., *presiding*. (Mountaineer Room).

Guest Speaker: Robert B. Greenblatt, M. D., Augusta, Georgia.

2:00—W. Va. Academy of Ophthalmology and Otolaryngology. Worthy W. McKinney, M. D., *presiding*. (Lee Room, Virginia Wing).

Business Meeting.

2:00—Section on Orthopedic Surgery. Carl J. Roncaglione, M. D., *presiding*. (Van Buren Room).

Guest Speaker: William M. Deyerle, M. D., Richmond, Virginia. Subject: "Fractures of the Hip—Plate and Multiple Pin Technique with Immediate Weight Bearing End Results."

2:00—Section on Urology. D. Franklin Milam, M. D., *presiding*. (Jackson Room).

There will be a discussion on "Experiences with Cryosurgery of the Prostate at the West Virginia University Medical Center."

2:00—West Virginia Radiological Society. E. Walter Rice, M. D., *presiding*. (Buchanan Room).

Business Meeting and Film Session.

2:00—W. Va. Society of Anesthesiologists. N. W. B. Craythorne, M. D., *presiding*. (Washington Room, Virginia Wing).

Business Meeting.

2:00—Section on Neurology, Neurosurgery and Psychiatry. W. E. Wilkinson, M. D., *presiding*. (West Virginia Room).

Guest Speaker: William J. German, M. D., Professor of Surgery, Yale University School of Medicine, New Haven, Connecticut. Subject: "Considerations Regarding Treatment of Intracranial Carotid Aneurysm." (This part of the program is sponsored by Merck Sharp & Dohme).

3:00—West Virginia Chapter, American Society of Internal Medicine. A. B. Curry Ellison, M. D., *presiding*. (Governor's Hall).

Business Meeting.

5:00—Committee on Nominations. L. J. Pace, M. D., *presiding*. (Lee Room, Virginia Wing).

FRIDAY EVENING

6:30—Cocktail Party, West Virginia Chapter, Medical College of Virginia Alumni Association. W. Fred Richmond, M. D., *in charge*. (West Virginia Room).

6:30—Cocktail Party, University of Virginia Alumni Fund—Medical Division. L. J. Pace, M. D., *in charge*.

10:00—Auxiliary Entertainment and Dance (Chesapeake Hall).

SATURDAY MORNING

August 27

8:00—Motion Pictures. John J. Mahood, M. D., *in charge*. (Governor's Hall). "For Those Who Drink," and "Thrombectomy in Acute Ileo-Femoral Venous Thrombosis."

8:30-2:30—Registration, Main Floor Lobby.

"WVU SCHOOL OF MEDICINE DAY"

Symposium on "The Problems of the Adolescent."

Moderator: William G. Klingberg, M. D.

9:30—William G. Klingberg, M. D., Professor and Chairman of the Department of Pediatrics. Subject: "Introduction to the Problems of the Adolescent."

Roland E. Schmidt, M. D., Assistant Professor of Pediatrics. Subject: "Adolescent Growth and Nutrition."

Paul Davidson, M. D., Instructor in Medicine. Subject: "Specific Medical Problems of Most Importance to the Adolescent."

Nicholas W. Fugo, M. D., Chairman of the Department of Obstetrics and Gynecology. Subject: "Gynecologic Growth and Problems in the Adolescent."

Robert L. Vosburg, M. D., Chairman of the Department of Psychiatry. Subject: "Emotional Development and Problems of the Adolescent."

11:00—Recess for Visiting Exhibits.

11:30—Panel Discussion and Question and Answer Period.

12:15—Recess for Lunch and Visiting Exhibits.

SATURDAY AFTERNOON

1:30—West Virginia Association of Pathologists. J. Evan Sadler, M. D., *presiding*. (Jackson Room).

Business Meeting.

2:30—Second and Final Session of the House of Delegates. Seigle W. Parks, M. D., *presiding*. (Chesapeake Hall).

Invocation—Tracy N. Spencer, Jr., M. D.

Presidential Address: Seigle W. Parks, M. D., President, West Virginia State Medical Association.

Introduction of President of Woman's Auxiliary to the West Virginia State Medical Association.

Presentation of AMA-ERF Check to Dr. Clark K. Sleeth, Dean of the West Virginia University School of Medicine.

Introduction of Honor Guests.

Introduction of Recipients of 1966 Medical Scholarship Awards.

Business Meeting.

Election of Officers.

Installation of Richard E. Flood, M. D., of Weirton, as President of the West Virginia State Medical Association.

SATURDAY EVENING

6:30-7:30—Cocktail Party and Reception Honoring Officers of the West Virginia State Medical Association (Chesapeake Hall Terrace).

CONVENTION SPEAKERS

(Biographical Sketches)

Dr. Edward R. Annis of Miami, Florida, a Past President of the American Medical Association, was born in Detroit.

Edward R. Annis, M. D.

Doctor Annis was graduated from the University of Detroit and received his M. D. degree in 1938 from Marquette University School of Medicine. He has served as Chief of the Department of Surgery at Mercy Hospital and attending physician at North Shore Hospital in Miami, Florida.

Doctor Annis has been active for many years in the affairs of local, state and national medical associations. He was named President Elect of the AMA during the Annual Convention in 1962 and was installed as President in June, 1963.

He is currently serving as a consultant to the AMA Advisory Committee on PL 89-97 (Medicare) and PL 89-239 (Regional Programs on Heart Disease, Cancer and Stroke).

Doctor Annis has many friends in West Virginia and has been a guest speaker at two previous meetings of the State Medical Association.

Dr. Paul C. Davidson, Assistant Professor of Medicine at the West Virginia University School of Medicine, was born in Springview, Nebraska.

Paul C. Davidson, M. D.

Doctor Davidson received his B. A. degree in 1953 from Macalester College and his M. D. degree in 1958 from the University of Minnesota.

He served his internship at the University of Minnesota Hospitals and did specialty training in a Veterans' Administration Hospital and the West Virginia University Medical Center.

Doctor Davidson also served a Fellowship in endocrinology and metabolism at the WVU Medical Center. He will speak Saturday morning on "Specific Medical Problems of Most Importance to the Adolescent."

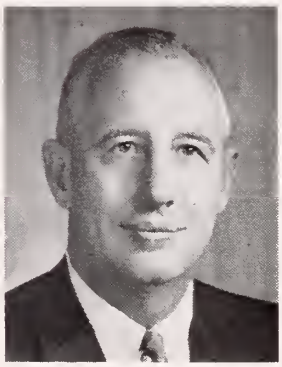
Dr. Paul F. deGara of New York City was born in Austria. Doctor deGara received M. D. degrees from Heidelberg in Germany in 1926 and from Padua in Italy in 1927. He is now serving as Clinical Associate Professor of Pediatrics-Allergy and Chief of the Pediatric-Allergy Clinic at the New York Hospital, Cornell Medical Center.

Paul F. deGara, M. D.

Doctor deGara is a Fellow of the American College of Allergists and the American Academy of Allergy. He is a Past President of the New York Allergy Society, and his other memberships include the New York Academy of Medicine and the American Medical Association.

Doctor deGara formerly served as Instructor in Bacteriology at the New York University College of Medicine and as Instructor in Pathology at Cornell University Medical College.

Dr. William M. Deyerle, Assistant Clinical Professor of Orthopedic Surgery at the Medical College of Virginia, was born in Bluefield.



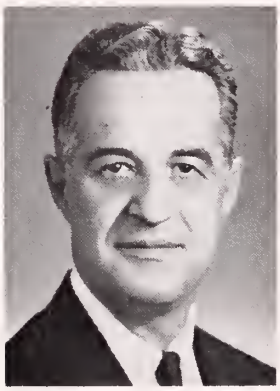
William M. Deyerle, M. D.

Doctor Deyerle was graduated from Davidson College and received his M. D. degree in 1940 from the University of Virginia School of Medicine. He interned at the Medical College of South Carolina and served residencies at the Medical College of Virginia Hospitals and The Crippled Children's Hospital in Richmond.

During World War II, he served for 31 months as a Captain in the Medical Corps of the United States Army.

Doctor Deyerle was certified by the American Board of Orthopedic Surgery in 1950, and he is a member of the American Academy of Orthopedic Surgeons, Association of Bone and Joint Surgeons and American Fracture Association. He serves as Associate Editor of *Clinical Orthopaedics and Related Research.*

Dr. Nicholas W. Fugo, Professor and Chairman of the Department of Obstetrics and Gynecology at the West Virginia University School of Medicine, was born in Syracuse, New York.



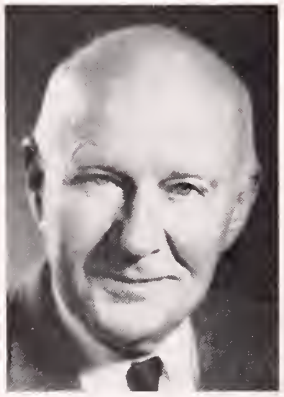
Nicholas W. Fugo, M. D.

He received his A. B. degree in 1935 from Syracuse University and earned M. S. and Ph. D. degrees from the State University of Iowa in 1937 and 1940. In 1950, he received his M. D. degree from the University of Chicago Medical School.

Doctor Fugo served as Research Associate in the Departments of Obstetrics and Gynecology and Pharmacology of the University of Chicago, 1946-54, and was Associate Professor of Obstetrics and Gynecology at the same institution when he accepted his present appointment at WVU in 1960.

He was certified by the American Board of Obstetrics and Gynecology in 1959. He is a member of the American College of Obstetricians and Gynecologists, the Association of American Medical Colleges and the Association of Professors of Obstetrics and Gynecology, and he is a Fellow of the American College of Surgeons.

Dr. William J. German, Professor of Surgery at the Yale University School of Medicine, was born in McKeesport, Pennsylvania.



William J. German, M. D.

Doctor German was graduated from the University of California and received his M. D. degree in 1926 from Harvard Medical School. He interned at Peter Bent Brigham Hospital in Boston, 1926-27, and served residencies at Johns Hopkins Hospital and Yale University School of Medicine, 1928-31. He joined the faculty at Yale University School of Medicine upon completion tion of his training and has served as Professor of Surgery since 1948.

He was certified by the American Board of Obstetlogical Surgery in 1940. During World War II he served in the Medical Corps of the United States Navy and was retired with the rank of Captain.

Doctor German is a past president of the Harvey Cushing Society and the Society of Neurological Surgeons. He was awarded an honorary degree by Yale University in 1948.

Dr. Robert B. Greenblatt, Professor and Chairman of the Department of Endocrinology at the Medical College of Georgia, is a native of Montreal, Canada.

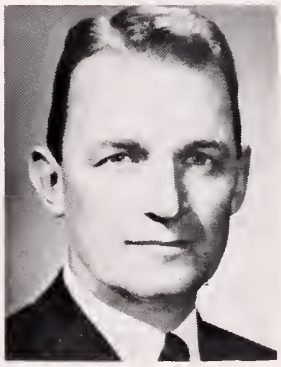
Robert B. Greenblatt, M. D.

Doctor Greenblatt received his M. D. degree in 1932 from the McGill University Faculty of Medicine. He took postgraduate work in pathology in Montreal and Boston and also served a residency in obstetrics and gynecology at University Hospital in Augusta.

He has been associated with the Medical College of Georgia since 1936 and at one time served as Assistant Professor of Pathology and Gynecology. Since 1946 he has served as Professor and Chairman of the Department of Endocrinology.

During World War II, he served with the Medical Corps of the United States Coast Guard (Pacific Fleet) and now serves as consultant to the Office of the Surgeon General, United States Army, and the Veterans Administration.

Dr. John R. Haserick, Professor and Director of the Department of Dermatology at The Cleveland Clinic Foundation, was born in Minneapolis.



John R. Haserick, M. D.

Doctor Haserick attended Macalester College and the University of Minnesota. He received his M. D. degree in 1941 from the University of Minnesota School of Medicine.

He interned at Ancker Hospital in St. Paul, 1940-41, and served a Fellowship in Medicine at the University of Minnesota Hospital, 1941-42. He served as a Captain in the Medical Corps of the United States Army, 1942-46.

Doctor Haserick served as an Instructor in Dermatology at the University of Minnesota, 1947-48, and then joined the staff of The Cleveland Clinic Foundation. He has served as Head of the Department of Dermatology since 1957. He also serves as Associate Clinical Professor of Dermatology at Western Reserve University of School of Medicine.

He was certified by the American Board of Dermatology in 1947. He is a member of the American Academy of Dermatology and several other dermatological organizations. He is a Fellow of the American College of Physicians.

Dr. Doris A. Howell, Professor and Chairman of the Department of Pediatrics at the Woman's Medical College of Pennsylvania, is a native of Brooklyn, New York.

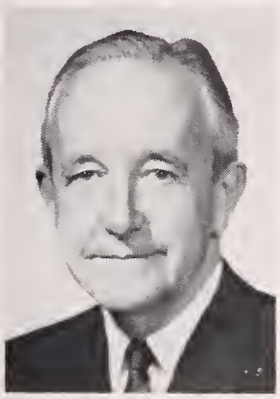
Doris A. Howell, M. D.

She was graduated from Park College and received her M. D. degree in 1949 from McGill University Faculty of Medicine.

She interned at Children's Memorial Hospital in Montreal, 1949-51, and served as senior assistant resident in pediatrics at Duke University Hospital, 1951-52. She had additional training at Harvard Medical School and Children's Medical Center in Boston, and served as Instructor in Pediatrics at Harvard Medical School.

Doctor Howell was certified in 1956 by the American Board of Pediatrics and she is a member of the American Medical Association, American Hematology Society, New York Academy of Science and the American Academy of Pediatrics.

Dr. Charles L. Hudson of Shaker Heights, Ohio, President of the American Medical Association, is a native of Merrill, Michigan.



Charles L. Hudson, M. D.

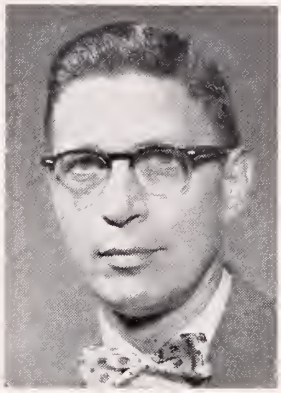
Doctor Hudson was installed as President of the AMA last June in Chicago. He was elected to the AMA Board of Trustees in 1961 and was reelected the following year to a five-year term. He was named President Elect during the AMA meeting in New York City in June, 1965.

Doctor Hudson received his M. D. degree in 1930 from the Medical School of the University of Michigan. After his internship and residency at Lakeside Hospital in Cleveland, he accepted a two-year research fellowship in pharmacology at the University of Pennsylvania. He returned to Lakeside Hospital as Chief Resident Physician in medical service, 1934-35.

A Diplomate of the American Board of Internal Medicine, Doctor Hudson has specialized in that field for 30 years. In addition to his practice, he holds associate professorships in medicine and preventive medicine at Western Reserve University. He is also director of the University Health Service.

Doctor Hudson is a member of the Cleveland Academy of Medicine and the Ohio State Medical Association, which he served as President in 1955-56.

Dr. William G. Klingberg, Professor and Chairman of the Department of Pediatrics at the West Virginia University School of Medicine, was born in Wichita, Kansas.



Wm. G. Klingberg, M. D.

Doctor Klingberg attended Municipal University in Wichita before receiving his M. D. degree in 1943 from the Washington University School of Medicine. He joined WVU in his present position in 1960 after serving as Associate Professor of Pediatrics at the Washington University School of Medicine.

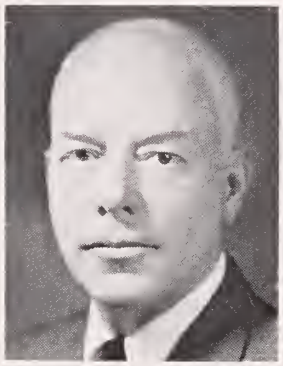
In 1957, Doctor Klingberg took a leave from Washington University to serve as Visiting Professor in the Department of Pediatrics at the Ankara University School of Medicine in Turkey for 18 months. In 1950, he was certified by the American Board of Pediatrics.

He is a member of the West Virginia and Pittsburgh Pediatric societies, the Midwest Society for Pediatric Research, and the American Pediatric and Hematology societies.

Doctor Klingberg is a member of the Committee which planned the program for the 99th Annual Meeting of the West Virginia State Medical Association.

Dr. James T. Priestley of The Mayo Clinic in Rochester, Minnesota, is a native of Des Moines, Iowa.

Doctor Priestley is Head of a Section of Surgery at The Mayo Clinic and Professor of Surgery at the Mayo Graduate School of Medicine, University of Minnesota.



James T. Priestley, M. D.

Doctor Priestley was graduated from the University of Pennsylvania and received his M. D. degree in 1926 from the University of Pennsylvania School of Medicine. He interned at the University of Pennsylvania Hospital in Philadelphia, 1926-28.

He received an M. S. degree in experimental surgery in 1931 and a Ph. D. in surgery in 1932 from the University of Minnesota. He served in the Medical Corps of the United States Army during World War II with the rank of Lieutenant Colonel.

Doctor Priestley served as President of the American College of Surgeons, 1964-65, and he is a member of a number of other scientific organizations. He was certified by the American Board of Surgery in 1940.

Dr. Roland E. Schmidt, Assistant Professor of Pediatrics at the West Virginia University School of Medicine, was born in Bemidji, Minnesota.

Roland E. Schmidt, M. D.

Doctor Schmidt received his B. A. degree in 1939 from the University of Washington. In 1945, he received his M. D. degree from the University of Chicago.

He served residencies in general practice at Huey P. Long Hospital in Louisiana and in pediatrics at the North Carolina Memorial Hospital.

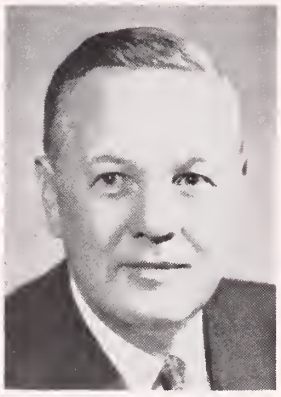
Doctor Schmidt is a Diplomate of the American Board of Pediatrics. He was Instructor in Pediatrics at North Carolina Memorial Hospital before joining the WVU faculty in 1964.

During the 1940s, Doctor Schmidt served as a First Lieutenant in the Medical Corps of the United States Army.

His research has been carried out through a North Carolina Heart Association Grant; WVU School of Medicine General Research Support Grant; Mead Johnson Grant for Pediatric Research; and a West Virginia Heart Association Grant.

Hulett C. Smith, Governor of West Virginia, is a native of Beckley.

Governor Smith is a son of the late Congressman Joe L. Smith and Christine Carlson Smith. He was educated in the public schools of Raleigh County, attended Beckley College and received a B.S. degree in economics from the Wharton School of Finance and Administration of the University of Pennsylvania.



Gov. Hulett C. Smith

During World War II, he served as a Lieutenant in the United States Navy. He returned to Beckley in 1946 where he was active in the business community. He served as a director and treasurer of the Beckley and Oak Hill hospitals from 1953 to 1965.

Governor Smith served as Chairman of the State Democratic Executive Committee from 1956 to 1961, and was appointed first Commissioner of the West Virginia Department of Commerce in 1963.

He was elected the 27th Governor of West Virginia on November 3, 1964, and was inaugurated on January 18, 1965.

He is married to the former Mary Alice Tieche of Beckley and they have five children.

Dr. Victor L. Szanton is engaged in the practice of pediatrics and pediatric allergy in Derby, Connecticut.

He received a B. A. degree in 1932 from the University of Alabama and his M. D. degree four years later from Duke University Medical School. He served a residency in pediatrics at Mt. Sinai Hospital in New York in 1938-39 and is a former Assistant Professor of Pediatric Allergy at Albert Einstein School of Medicine.

Victor L. Szanton, M. D.

Doctor Szanton's hospital staff positions include those of Attending Pediatric Allergist at Griffin Hospital in Derby, Attending Pediatrician at St. Raphael's Hospital in New Haven, and Assistant Attending Pediatrician at New Haven Hospital.

He is a member of the New York Academy of Science and the New England Pediatric and Allergy societies. He is also Chairman of the Pediatric Section of the American College of Allergists, a Fellow of the American Academy of Allergists and the American Academy of Pediatrics, and a Diplomate of the American Board of Pediatrics.

Doctor Szanton is a regional consultant for the Jewish National Home for Asthmatic Children in Denver and for the Association of Convalescent Homes and Hospitals for Asthmatic Children, Inc. He is a member of the Editorial Board of the *Connecticut Medicine*.

Dr. Robert L. Vosburg, Professor and Chairman of the Department of Psychiatry at the West Virginia University School of Medicine, is a native of Detroit.

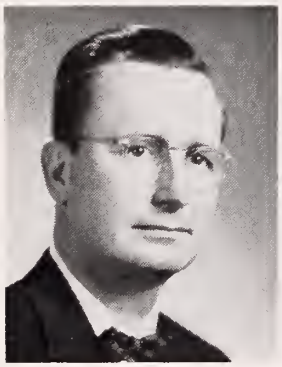
Robert L. Vosburg, M. D.

Doctor Vosburg attended the University of Notre Dame and Michigan State University before receiving his M. D. degree in 1951 from the University of Chicago. He served his psychiatric residency at Western Psychiatric Institute and Clinic in Pittsburgh.

He was Assistant Professor of Psychiatry at the University of Pittsburgh School of Medicine before joining the WVU faculty in 1963.

Doctor Vosburg is a Fellow of the American Psychiatric Association and is a member of the Pittsburgh Neuropsychiatric Society and the Pennsylvania Psychiatric Society.

Dr. Robert I. Wise, Magee Professor of Medicine and Head of the Department at Jefferson Medical College in Philadelphia, was born in Barstow, Texas.



Robert I. Wise, M. D.

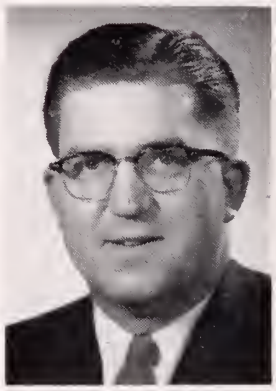
He was graduated from the University of Texas. He received a Ph. D. degree in 1942 from the University of Illinois and an M. D. degree in 1950 from the University of Texas School of Medicine.

He interned at the U. S. Public Health Service Hospital in New Orleans, 1950-51, and served a residency at the University of Minnesota, 1951-53. He served for two years as Assistant Professor of Medicine at the University of Minnesota School of Medicine.

Doctor Wise, who also serves as Physician-in-Chief at Jefferson Medical College Hospital, was certified by the American Board of Internal Medicine in 1957.

Doctor Wise is a Fellow of the American College of Physicians and is a member of the Editorial Board of *Annals of Internal Medicine.* He also serves as a member of the Advisory board of *The Medical Letter.*

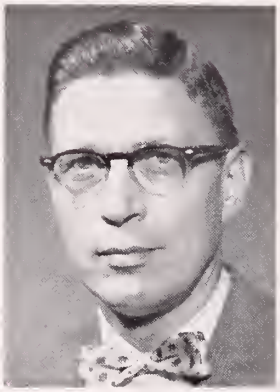
1966 PROGRAM COMMITTEE



Carl B. Hall, M. D.
Charleston
Chairman

William E. Gilmore, M. D.
Parkersburg

Halvard Wanger, M. D.
Shepherdstown



Wm. G. Klingberg, M. D.
Morgantown

DELEGATES AND ALTERNATES

B-R-T (3)—Delegates, Charles L. Leonard, Elkins; A. Kyle Bush, Philippi; and Homer D. Martin, Dailey. Alternates, Raymond W. Cronlund, Philippi; E. E. Hutton, Jr., Elkins; and Karl J. Myers, Philippi.

BOONE (2)—Delegates, David E. Wallace, Madison; and W. V. Wilkerson, Whitesville. Alternates, Harold H. Howell, Madison.

BROOKE (2)—Delegates, W. T. Booher, Jr., and H. L. Hegner, Wellsburg. Alternates, J. P. McMullen, Wellsburg; and J. E. Wise, Follansbee.

CABELL (8)—Delegates, Joseph E. Ricketts, Roy A. Edwards, Jr., David A. Haught, Joseph M. Farrell, John F. Otto, Jr., Walter R. Wilkinson, Thomas J. Holbrook and Thomas F. Scott, Huntington. Alternates, Richard J. Stevens, R. R. Hagley, John M. Bobbitt, C. Stafford Clay, W. L. Neal, James P. Carey, I. Ewen Taylor and Thomas G. Folsom, Huntington.

CENTRAL WEST VIRGINIA (3)—Delegates, Charles Lively, Weston; John E. Echols, Richwood; and R. L. Chamberlain, Buckhannon. Alternates, J. C. Huffman, Buckhannon; Edward H. Hunter, Richwood; and C. R. Davisson, Weston.

EASTERN PANHANDLE (3)—Delegates, E. Walter Rice, Martinsburg; Halvard Wanger, Shepherdstown; and Daniel E. Hendricks, Martinsburg. Alternates, E. Andrew Zepp and Leo H. T. Bernstein, Martinsburg; and S. Elizabeth McFetridge, Shepherdstown.

FAYETTE (2)—Delegates, Joe N. Jarrett and W. P. Bittinger, Oak Hill. Alternates, W. B. Davis, Rainelle; and T. Kerr Laird, Montgomery.

GREENBRIER VALLEY (3)—Delegates, Luther E. Rexrode, Marlinton; and Arnold J. Brody and Stuart T. Bray, White Sulphur Springs.

HANCOCK (3)—Delegates, Ray S. Greco, J. L. Thompson and Dominic A. Brancazio, Weirton. Alternates, Myer Bogarad, Weirton.

HARRISON (4)—Delegates, Paul E. Gordon, L. Dale Simmons, Clarksburg; Ray A. Harron, Bridgeport; and Albin A. Galuszka, Clarksburg. Alternates, George F. Evans, Andrew J. Weaver, Richard V. Lynch, Jr., and Bolyston D. Smith, Jr., Clarksburg.

KANAWHA (13)—Delegates, George R. Callender, Duke A. Dent, A. B. Curry Ellison, Jerill D. Cavender, James H. Getzen, Andrew W. Goodwin, II, and Carl B. Hall, Charleston; E. Q. Hull, South Charleston; Kenneth G. MacDonald, Theodore P. Mantz, William B. Rossman, Page H. Seekford and P. A. Tuckwiller, Charleston. Alternates, John T. Chambers, Charleston; William D. Crigger, South Charleston; Donald E. Cunningham, St. Albans; Donald R. Gilbert, Henry R. Glass, Jr., George L. Grubb, Peter A. Haley, J. Dennis Kugel, Milton J. Lilly, Jr., and Morris H. O'Dell, Charleston; Joseph A. Smith, Dunbar; and Charles Staats and R. R. Summers, Charleston.

LOGAN (3)—Delegates, Thomas P. Long and Harold Van Hoose, Man. Alternates, Mark S. Spurlock and Ray M. Kessel, Logan.

MARION (3)—Delegates, Robert R. Frye, Mannington; and Joseph T. Mallamo and Jack C. Morgan, Fairmont. Alternates, F. W. Mallamo, Robert G. Janes and Rupert W. Powell, Fairmont.

MARSHALL (2)—Delegates, Andrew J. Barger, Glen Dale; and William Paul Bradford, Moundsville.

MASON (2)—Delegates, Dan Glassman and Kenneth N. Byrne, Point Pleasant. Alternates, C. Leonard Brown and Richard L. Slack, Point Pleasant.

McDOWELL (3)—Delegates, A. J. Villani, J. Hunter Smith and Arthur Allen Carr, Welch. Alternates, R. H. Edwards, Guy E. Irvin and Charles F. McCord, Welch.

MERCER (4)—Delegates, W. Hampton St. Clair, Jr., E. W. McCauley, Upshur Higginbotham and John J. Mahood, Bluefield. Alternates, David F. Bell, Jr., Bluefield; John I. Markell, Princeton; and Charles M. Scott and Henry F. Warden, Jr., Bluefield.

MINGO (2)—Delegates, Robert J. Tchou and Arthur E. Levy, Williamson. Alternates, L. Lake Swigart and Russell A. Salton, Williamson.

MONONGALIA (5)—Delegates, Robert Greco, William E. King, George A. Curry, Charles E. Andrews and Clark K. Sleeth, Morgantown. Alternates, Robert J. Fleming, Ralph W. Ryan, Benjamin M. Stout, Jr., and Arthur W. Kelley, Morgantown.

OHIO (6)—Delegates, Harry S. Weeks, D. E. Greeneltch, Howard G. Weiler, John Mark Moore, A. L. Wanner and Robert T. Brandfass, Wheeling. Alternates, Thomas L. Thomas, Joseph L. Curry, E. Lee Jones, N. K. Joseph, James E. Spargo and Stephen D. Ward, Wheeling.

PARKERSBURG ACADEMY (5)—Delegates, Charles H. Barnett, William E. Gilmore, Charles W. Thacker and Robert C. Lincicome, Parkersburg; and Jack J. Stark, Belpre, Ohio. Alternates, Richard W. Corbitt, R. C. Cowan, Jr., and S. William Goff, Parkersburg; George W. West, St. Marys; Asel P. Hatfield, Harrisville; Watson F. Rogers, Vienna; Lyle D. Vincent, Parkersburg; and David L. Mandry, Ravenswood.

POTOMAC VALLEY (3)—Delegates, Vernon L. Dyer, Petersburg; Harry F. Coffman, Keyser; and Lysle T. Veach, Petersburg. Alternates, Charles J. Sites, Franklin; and Robert W. Bess, Jr., Piedmont.

PRESTON (2)—Delegates, Del Roy R. Davis and Donald P. Brown, Kingwood. Alternates, William H. Harriman, Jr., Terra Alta; and W. Parke Johnson, Jr., Masontown.

RALEIGH (4)—Delegates, W. Fred Richmond, Warren D. Elliott, M. M. Ralsten and George A. Miller, Beckley. Alternates, Asa Barnes, Charles W. Merritt, Harry F. Cooper and Richard G. Starr, Beckley.

SUMMERS (2)—Delegates, Jack D. Woodrum and Buford W. McNeer, Hinton. Alternates, A. W. Holmes and D. W. Ritter, Hinton.

TAYLOR (2)—Delegates, Charles A. Haislip, Grafton. Alternates, Wallace B. Murphy and Gene W. Harlow, Grafton.

WETZEL (2)—Delegates, John O. Theiss and Lemoyne Coffield, New Martinsville. Alternates, Kent M. Hornbrook, New Martinsville; and R. F. Miller, Paden City.

WYOMING (2)—Delegates, Aarom Boonsue and Ross E. Newman, Mullens. Alternates, Frank J. Zsoldos and Ward Wylie, Mullens.

Reception Committee

James S. Klumpp, *Chairman*

C. A. Hoffman
Frank J. Holroyd
Bert Bradford
Richard E. Flood

Albert C. Esposito
George A. Curry
Richard V. Lynch, Jr.
Thomas G. Reed

B. B. Richmond
George R. Callender. Jr.
John W. Hash
Kenneth G. MacDonald

Harry F. Cooper
William E. Gilmore
I. Ewen Taylor
Bernard Zimmermann

Dwight P. Cruikshank
A. J. Villani
Daniel A. Mairs
Nicholas W. Fugo

William A. Welton
H. Charles Ballou
Hunter Boggs
W. Carroll Boggs

Arnold J. Brody
E. L. Crumpacker
George F. Evans
Edmund B. Flink

Carl J. Roncaglione
Henry M. Hills, Jr.
J. C. Pickett
Howard G. Weiler

Halvard Wanger
W. Gene Klingberg
Russell V. Lucas, Jr.
Robert D. Crooks

Andrew J. Weaver
Richard W. Corbitt
J. C. Huffman
L. J. Pace

Official Program
WOMAN'S AUXILIARY
to the

West Virginia State Medical Association
42nd Annual Meeting

The Greenbrier
White Sulphur Springs
August 25-27, 1966

WEDNESDAY
August 24

3:00—First Session of the House of Delegates, State Medical Association (Chesapeake Hall).

Address by Charles L. Hudson, M. D., President of the American Medical Association.

(Auxiliary Members are Invited and Urged to Attend).

4:00—Pre-Convention Board Meeting. Mrs. Wilson P. Smith, President, *presiding* (Pierce Room).

THURSDAY MORNING
August 25

9:00—Formal Opening of the 99th Annual Meeting of the West Virginia State Medical Association (Governor's Hall).

Address by Hon. Hulett C. Smith, Governor of the State of West Virginia.

(Auxiliary Members are Invited to Attend).

9:30—Formal Opening of the Convention, Mrs. Wilson P. Smith, President, *presiding* (Fillmore and Van Buren Rooms).

Invocation—The Rev. Douglas N. Shepherd, Emmanuel Methodist Church, White Sulphur Springs.

Pledge of Loyalty—Mrs. Charles E. Andrews.

Welcome—Mrs. D. Sheffer Clark.

Response—Mrs. Paul P. Warden.

Introduction of Honor Guests.

Presentation of Seigle W. Parks, M. D., President, West Virginia State Medical Association.

Introduction of Convention Chairmen, Mrs. Frank M. Peck and Mrs. Ronald E. Crissey.

Roll Call of Delegates, Mrs. Joe N. Jarrett.

Convention Rules of Order, Mrs. Pat A. Tuckwiller, Parliamentarian.

Treasurer's Report, Mrs. J. Dennis Kugel.

In Memoriam, Mrs. Myer Bogarad.

Credentials and Registration, Mrs. M. L. White, Jr.

Keynote Address—Mrs. Asher Yaguda, President, Woman's Auxiliary to the American Medical Association.

Recommendations from Pre-Convention Board Meeting, Mrs. Wilson P. Smith.

New Business and Announcements.

Report of Revisions Committee.

Report of Nominating Committee, First Reading, Mrs. George A. Curry, Chairman.

Presentation of Mrs. William G. Thuss, President, Woman's Auxiliary to the Southern Medical Association.

Election of 1967 Nominating Committee.

Reports from Officers and Standing Committee Chairmen Will Not Be Read As They Were Published in the Annual Reports Book.

Presentation of County Presidents by the Vice Presidents:

First Vice President, Mrs. John A. B. Holt.
Second Vice President, Mrs. C. R. Davisson.
Third Vice President, Mrs. Rupert W. Powell.
Fourth Vice President, Mrs. Ray M. Kessel.

Highlights from the National Convention in Chicago, Mrs. Pat A. Tuckwiller.

THURSDAY AFTERNOON

1:00—Christmas Luncheon. Ann Wertsner Wood Presents "Make Your Own Merry Christmas."
Visit the Exhibits. Exhibit Center Open Until 3:30 P. M.

THURSDAY EVENING

9:30—WESPAC Meeting. Speaker: Edward R. Annis, M. D., Past President of the American Medical Association.

FRIDAY MORNING
August 26

8:00—Past President's Breakfast, Mrs. George A. Curry, Immediate Past President, *presiding* (Director's Room).

9:30—Second General Session, Mrs. Wilson P. Smith, President, *presiding* (Fillmore and Van Buren Rooms).

Introduction of Honor Guests.

Address—Mr. J. E. Swan, Secretary of the National Electrical Contractors Association, Washington, D. C. Subject: "So You Married a Doctor."

Report of Reading Committee.

Convention Announcements, Mrs. Frank M. Peck.

Presentation of Edward R. Annis, M. D., Past President of the American Medical Association.

Reports of Convention Committees:

Finance—Mrs. Harry E. Beard.

Courtesy Resolutions—Mrs. Robert J. Tchou.

Credentials and Registration—Mrs. M. L. White, Jr.

Press and Publicity—Mrs. John E. Echols.

Report of Nominating Committee, Second Reading—Mrs. George A. Curry.

Election of Officers.

Report of President.

Installation of Officers, Mrs. Asher Yaguda, President of the Woman's Auxiliary to the American Medical Association.

Presentation of President's Pin and Gavel—Mrs. Wilson P. Smith.

Presentation of Past President's Pin—Mrs. George A. Curry.

Inaugural Address—Mrs. Hu C. Myers.

Announcements.

Adjournment.

FRIDAY AFTERNOON

1:00—Bridge Party, Mrs. Harold N. Kagan, Chairman. Bowling Tournament, Mrs. C. Stafford Clay, Chairman.

Golf Tournament, Mrs. H. C. Wasson, Jr., Chairman.

FRIDAY EVENING

10:00 P. M. to 1:00 A. M.—Dixieland Ball. Host: Cabell County Medical Society (Chesapeake Hall).

SATURDAY MORNING

August 27

10:00—Post-Convention Conference and Board Meeting. Mrs. Hu C. Myers, President, *presiding*.

(Fillmore and Van Buren Rooms).

SATURDAY AFTERNOON

2:30—Second and Final Session of the House of Delegates of the State Medical Association (Chesapeake Hall).

Presidential Address by Seigle W. Parks, M. D., President of the West Virginia State Medical Association.

Installation of Dr. Richard E. Flood as President of the West Virginia State Medical Association.

(Auxiliary Members are Invited and Urged to Attend).

SATURDAY EVENING

6:30-7:30—Cocktail Party and Reception Honoring the Officers of the West Virginia State Medical Association (Chesapeake Hall Terrace).

Arts and Crafts Exhibit

The Woman's Auxiliary to the West Virginia State Medical Association will sponsor an Arts and Crafts Exhibit during the Annual Meeting at The Greenbrier in White Sulphur Springs.

Auxiliary members, their husbands and members of their families have been invited to participate in the Exhibit. The classifications include painting, sculpture, woodcraft, ceramics, handcraft, needlework, and photography and lithography.

The Exhibit will be housed in the Exhibit Center. Persons interested in submitting an entry should register at the Auxiliary desk on the main floor lobby.

SCIENTIFIC EXHIBITS

(Exhibit Center)

ALLERGY REHABILITATION FOUNDATION INC.

"Broncho Junction—A Rehabilitation Summer Camp for Asthmatic Children"—This eight-week summer camp near Charleston provides rehabilitation recreation programs for children with bronchial asthma. The aim is to prepare these children for a normal physical and emotional development through medical treatment, physical conditioning and camping activities. A competent staff of allergy physicians, graduate nurses, dietitians, instructors and counselors is in constant attendance.

Merle S. Scherr, M. D., Medical Director.

AMERICAN CANCER SOCIETY W. VA. DIVISION, INC.

"Checkups ARE Worthwhile"—This exhibit affirms the value of periodic health examinations, particularly with reference to improved end results of treatment of breast, colon and rectum, cervix, lung and oral cancer through the presentation of data on detection and treatment experience.

William A. Nichols, Executive Director.

AMERICAN MEDICAL ASSOCIATION DEPARTMENT OF INVESTIGATION

"Information On Chiropractic"—The educational exhibit presents factual, objective data on the practice of chiropractic in the United States, including information on chiropractic theory, methods and education. Eight facts documented by reputable source material describe vulnerable areas for criticism of chiropractic. Six devices commonly used by chiropractors in their practice are pictured and described. Three of the six devices have been the subject of Federal Food and Drug Administration seizure actions. Literature is available.

H. Doyl Taylor, LL.B., Director, and Robert A. Youngerman, LL.B., Staff Associate, Chicago.

AMERICAN MEDICAL ASSOCIATION DEPT. OF MEDICINE AND RELIGION

Literature will be available on the American Medical Association's Medicine and Religion Program.

DIVISION OF VOCATIONAL REHABILITATION

This year's exhibit will feature the "Story of the Rehabilitation Process" through the use of a plyboard, blue and gold display with attached magnetic-backed blocks, giving the accomplishments for the past six years of the West Virginia Rehabilitation Division. The exhibit has been prepared by the Information and Publications Office and the drafting class at the Vocational Center at Institute.

Earl W. Wolfe, Acting Director.

DUODENAL OBSTRUCTION IN INFANTS

This exhibit is based on cases seen at Broaddus Hospital and Myers Clinic in Philippi. Line drawings are used to illustrate the type of obstruction. Extrinsic types of obstruction are rue to malrotation with or without mid-gut volvulus and annular pancreas. Intrinsic types of obstruction are due to atresia of duodenum. Symptoms and signs are (1) vomiting, usually greenish, (2) fullness in upper abdomen, and (3) x-rays with or without contrast media. If contrast media is used, Oragrafin is preferred. Methods of correction are also shown. Favorable outcome shows (1) replacement of fluid and electrolyte imbalance which occurs rapidly in infants due to a larger surface area per unit of body weight as compared with adults, (2) early operation, and (3) gentle and precise surgical technique with minimal handling of GI tract.

A. Kyle Bush, M. D.

EPILEPSY ASSOCIATION OF AMERICA AND AFFILIATED O. C. INSTITUTE EPILEPSY DIVISION

Emergency MEDICAL IDENTIFICATION, recommended for everyone by the American Medical Association, will be featured. The exhibit will also display drugs used in the treatment of various convulsive disorders and EEG seizure patterns. Pamphlets and other material prepared by the Epilepsy Association of America will be available.

Richard Smalley, President, and M. G. Stemmermann, M. D., Professional Advisor.

MINIMIZING THE MENOPAUSE

The rational of regarding the menopause as a deficiency disease is presented. Adequate replacement therapy with estrogen and progesterone will minimize its multiple disorders, such as: Insomnia, Depression, Arthralgia, Fatigability, Incontinence, Sweating, Emotional Instability, Senile Vaginitis, Headache, and Hot Flashes. A compilation of results achieved on patients in private practice in reducing the severity of these most frequent symptoms is also graphically presented.

F. P. Rhoades, M. D., Detroit, Michigan.

SOCIAL SECURITY ADMINISTRATION

"Health Insurance For The Aged"—This display shows Medicare information of interest to the physician. It emphasizes the hospital insurance and the medical insurance parts of the Medicare Program and the nature and extent of health services for which costs may be paid under each part of the program.

SOUTHERN MEDICAL ASSOCIATION

This exhibit describes the educational features supported by the Southern Medical Association, such as *The Journal* and the Annual Meeting. It also points out the advantages of membership in the SMA.

Martha Hooks, Birmingham, Alabama.

THE NATIONAL FOUNDATION MARCH OF DIMES

This exhibit presents by means of models, diagrams and pictures the suggested relationship between deoxyribonucleic acid in chromosomes, as inferred from bacterial genetics, and the relationship between abnormal chromosome patterns and congenital anomalies.

Charles W. Dawkins, Field Representative.

TREATMENT OF BLEEDING DISEASES AND THEIR INCIDENCE IN WEST VIRGINIA

Data concerning the incidence of congenital bleeding diseases in West Virginia has been compiled from a recent questionnaire circulated to all physicians in the State. The approximate numbers of such affected persons in each county will be displayed.

Recent advances in the fractionation of blood to concentrate anti-hemophilic globulin—Factor VIII—have improved the treatment of acute bleeding in the severe hemophiliac patient. Information concerning commercial sources and potency of two concentrates will be displayed. The preparation of a third, by the recently described cryoprecipitation method of Pool and Robinson, will be illustrated. This method of processing individual units of blood, which can be used by any moderately large blood bank, is simple and inexpensive. Other fractions, such as platelet concentrates can be prepared from the same unit. Alternatively, the blood can be reconstituted and used in any situation except those in which bleeding is associated with anti-hemophilic globulin deficiency.

Mabel M. Stevensen, M. D., and Miss M. E. Harbaugh, Clinical Laboratories, West Virginia University Hospital.

WEST VIRGINIA ASSOCIATION FOR RETARDED CHILDREN

This exhibit will feature preventable and treatable conditions associated with mental retardation. Volunteers from the Association and the Federated Women's Clubs will demonstrate the Berry "spot" tests for inborn metabolic errors. Facilities available in West Virginia for rehabilitation and treatment will also be displayed. Literature related to specific problems of the retarded will be supplied.

Marjorie Martuffi, President.

WEST VIRGINIA ASSOCIATION OF MEDICAL ASSISTANTS

Literature will be available concerning the Association, its goals, advantages to both the doctor and the medical assistant, and the many educational programs available.

Mrs. Lyda Plymale, Educational Director.

WEST VIRGINIA DEPARTMENT OF HEALTH

"Stroke Is A Community Problem"—The exhibit encourages the community to initiate a stroke program to coordinate existing resources or develop new ones so the physician can prescribe good rehabilitation services for his stroke patients. A telestory projector gives a picture story of these services and shows a patient's step-by-step return to active life.

Dr. Earl Simmons and Mr. Ronald LaNeve, U. S. Public Health Service.

WEST VIRGINIA DEPARTMENT OF HEALTH

"Hill-Burton Projects in West Virginia"—This exhibit features an outline map of West Virginia showing counties, cities and towns in which Hill-Burton projects are under construction or have been completed. Color coded lights are used to indicate new general hospitals, additions to medical facilities, public health centers and long-term care facilities and their locations.

WEST VIRGINIA DEPARTMENT OF MENTAL HEALTH

"Mental Health Services for West Virginians"—The exhibit will consist of a projector and slides depicting services to patients at state mental hospitals and community clinics. Physicians will find available various publications, including a booklet on the new commitment procedures.

Mildred Bateman, M. D., Director.

WEST VIRGINIA HEART ASSOCIATION

"Differential Diagnosis of Stroke"—The West Virginia Heart Association Professional Education Exhibit is designed to test the physician's diagnostic ability. Four panels with pertinent laboratory data are correlated with a written history of each case. Physicians taking the test will not be required to turn in or sign anything. Take the test, check your answers and discuss any questions with the physician attendant. You may keep the test booklet containing the questions and answers.

O. D. Wyatt, Executive Director.

WEST VIRGINIA SOCIETY OF INTERNAL MEDICINE

The West Virginia Society of Internal Medicine exhibit is composed of the official seal of the Society, and on the table will be displayed various pamphlets and other helpful information for members of the Society and other interested physicians. The West Virginia Society of Internal Medicine is a charter member of the American Society of Internal Medicine, which now has almost 9,000 internists as members.

A. B. Curry Ellison, M. D., President.

WEST VIRGINIA TUBERCULOSIS AND HEALTH ASSOCIATION

"Emphysema—A New Definition"—Pulmonary emphysema and chronic bronchitis are defined, and their physiological manifestations, pathology, and classifications are dealt with. A major panel simulates a breathing lung; x-rays and enlargements of slides of tissues further illustrate the information.

Thomas A. Deveny, Jr., Executive Director.

U. S. PUBLIC HEALTH SERVICE

"Pathology Of Coal Workers' Pneumoconiosis"—This exhibit presents representative cases of simple and complicated soft coal workers' lung disease. Included are x-rays, pulmonary function studies, vectorcardiographs, right heart catherization data, gough sections of post-mortem lungs, post-mortem x-rays, histology, and spectographic analysis of lung tissue. Summarized are data from 16 right heart catherizations, 202 autopsies, and a prevalance study which indicates 10 per cent of working miners in the Appalachian area and 20 per cent of inactive miners have x-ray evidence of this type of pneumoconiosis.

H. A. Wells, Jr., M. D.

West Virginia Wing at The Greenbrier

INDUSTRIAL EXHIBITS

(Exhibit Center)

ABBOTT LABORATORIES
North Chicago, Illinois
Booth 7

CIBA PHARMACEUTICAL COMPANY
Summit, New Jersey
Booth 8

CIBA Professional Service Representatives would be pleased to discuss the product Ser-Ap-Es.

Representatives: M. K. Ballengee and J. A. Adkins.

THE COCA-COLA COMPANY
Atlanta, Georgia
Booth 43

Ice cold Coca-Cola served through the courtesy and cooperation of the Coca-Cola Bottling Company of Clifton Forge, Inc., and The Coca-Cola Company.

ENCYCLOPAEDIA BRITANNICA
Chicago, Illinois
Booth 29

Encyclopaedia Britannica welcomes delegates to the West Virginia State Medical Association meeting and invites them to examine the great new edition of Britannica. Official delegates may now purchase this magnificent set at an offer only available at our convention exhibits. Visit Britannica's Booth No. 29.

ENDO LABORATORIES, INC.
Garden City, New York
Booth 17

ENDO LABORATORIES will present the latest clinical information relating to our products, COUMADIN® (SODIUM WARFARIN), NUMORPHAN® (OXYMORPHONE) HCL, PERCODAN®-DEMI, HYCOMINE®, HYCOMINE®-COMPOUND, HYCODAN®, VALPIN® (ANISOTROPINE METHYLBROMIDE), VALPIN®-PB (ANISOTROPINE METHYLBROMIDE WITH PHENOBARBITAL).

GEIGY PHARMACEUTICALS
Yonkers, New York
Booth 16

Geigy Pharmaceuticals cordially invites members and guests of the Association to visit its exhibit. The exhibit features important new therapeutic developments in the management of cardiovascular disease as well as current concepts in the control of inflammation; hypertension and edema; depression; obesity, and other disorders, which may be discussed with representatives in attendance.

HOSPITAL & PHYSICIANS SUPPLY COMPANY
Charleston, West Virginia
Booth 46

You are cordially invited to visit our booth located in Space No. 46. Our exhibit will consist of the latest in Burdick new EK-4 Dual-Speed Electrocardiograph, new Fiber-Optic diagnosic instruments by Welch-Allyn, Castle and Pelton Autoclaves, and all types of emergency resuscitation equipment. We sincerely thank you for your patronage this past year, and shall look forward to visiting with you again.

Representatives: Robert E. Lee Frazier, Robert K. Thacker and Gordon H. Davis.

ELI LILLY AND COMPANY
Indianapolis, Indiana
Booth 44

You are cordially invited to visit the Lilly exhibit. Our sales representatives in attendance welcome your questions about Lilly products. You may be particularly interested in discussing C-QUENS™ Sequential folder containing fifteen 80-mcg. tablets of mestranol plus five tablets each combining 80 mcg. mestranol and 2 mg. chlormadinone acetate, or KEFLIN® Sodium Cephalothin.

Representatives: H. B. Robinson and Jack Carter.

McLAIN SURGICAL SUPPLY, INC.
Charleston, West Virginia
Booth 19

We are featuring Diapulse, a new bioelectrical modality for the safe treatment of the entire patient through the stimulation of the host defense mechanism by pulsed high frequency therapy, without pyrexia. Also, for your perusal, we will display the new Beck-Lee EKG and many other new items.

Representatives: Jack Schwarz and Dick Hightower.

S. E. MASSENGILL COMPANY
Bristol, Tennessee
Booth 2

Best wishes from Massengill to the West Virginia State Medical Association for a most successful meeting. Our representatives will welcome the opportunity to discuss products of interest to you. On display will be several Massengill specialty preparations, and literature will be available, should you desire it.

MEAD JOHNSON LABORATORIES
Evansville, Indiana

Booth 21

The Mead Johnson Laboratories' exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about their products.

MEDICAL ARTS SUPPLY COMPANY
Huntington, West Virginia

Booth 42

We extend to you a cordial invitation to visit with us at our exhibit. We look forward to seeing and talking with you and will be happy to have the opportunity to show and discuss with you the various new items that we have on display that we know will be of great interest to you as aids in the diagnosis and treatment of your patients.

Representatives: M. L. Clovis and Roy Childers.

MERCK SHARP & DOHME
West Point, Pennsylvania

Booth 13

The Merck Sharp & Dohme exhibit has been designed to supplement the physician's therapeutic armamentarium. Technically trained personnel are present to discuss the scope and variety of services offered.

Representatives: Maurice S. Robertson and Marlen J. Klopp.

PARKE, DAVIS & COMPANY
Detroit

Booth 4

Medical service members of our staff are in attendance at our booth to discuss important Parke-Davis specialties which will be on display.

Representatives: Bruce Thompson and R. K. Hamilton.

PFIZER LABORATORIES
New York City

Booth 15

Professional Service Representatives from Pfizer Laboratories will be pleased to have you in attendance at their booth to discuss the latest products of Pfizer research.

PHYSICIANS NATIONWIDE, INC.
Charleston, W. Va.

Booth 28

Physicians Nationwide, Inc., is an association of Northwestern Mutual Life Insurance Agents—coast to coast—who specialize in working with physicians. Their objective is to provide professional service to the physician in estate and financial planning. The regional vice presidents for West Virginia are Hugh Thompson and Pete White. They welcome an opportunity to answer your questions and explain the services of PNI.

Representatives: Hugh Thompson and Pete White.

WM. P. POYTHRESS & CO., INC.
Richmond, Virginia

Booth 3

The Poythress exhibit will feature Trocinate, a unique, direct-acting (musculotropic) antispasmodic drug, and the Mudrane combinations, established Poythress products for relief of bronchial asthma. Solfoton, Solfo-Serpine, Panalgesic and Synirin will also be featured. Your requests for literature and professional trial quantities are cordially invited.

Representative: Hugh Mackey.

ROCHE LABORATORIES
Nutley, New Jersey

Booth 24

Continuing Roche research has produced outstanding contributions to medicine since 1909. The personnel at the exhibit welcome your comments, questions or suggestions about our products and services.

Representatives: Lacy W. Corbett and John Plymale.

J. B. ROERIG AND COMPANY
New York City

Booth 5

J. B. Roerig & Compny will welcome members of the medical profession at the Company's exhibit of leading specialty products. Representatives will be in attendance to answer any questions you may have. Roerig recently introduced a number of new products which representatives at the exhibit will be pleased to discuss with you.

Representatives: Dan Lynch, Barry Jones and Ray Piercy.

WILLIAM H. RORER, INC.
Fort Washington, Pennsylvania

Booth 14

William H. Rorer, Inc., takes great pride in exhibiting its fine pharmaceutical products at this convention. Our representatives will gladly discuss the merits of these products with you.

ROSS LABORATORIES
Columbus, Ohio

Booth 11

Ross Laboratories presents these pediatric products:

SIMILAC 20 Hospital Infant Feeding Procedure.
PEDIALYTE Oral Electrolyte Solution.
PEDIAMYCIN oral antibiotic effective against most pediatric bacterial infections.
VI-DAYLIN Polyvitamins reformulated according to National Research Council recommendations.
PEDIAFLOR Fluoride Drops for dental prophylaxis based on recommendation in *Accepted Dental Remedies.*

SANDOZ PHARMACEUTICALS
Hanover, New Jersey

Booth 12

Sandoz Pharmaceuticals cordially invites you to visit our display at Booth No. 12, where we are featuring Mellaril, Sansert, Cafergot P-B, Fiorinal and Fiorinal with codeine.

Representative: Danny Williams.

W. B. SAUNDERS COMPANY
Philadelphia, Pennsylvania
Booth 45

SCHERING CORPORATION
Bloomfield, New Jersey

Booth 20

Schering Corporation invites you to visit their exhibit, Booth No. 20, where their representatives will be available to discuss with you any questions you may have on AFRIN®, ETRAFON®, CELESTONE®, SOLUSPAN®, TINACTIN® or any other Schering product.

E. R. SQUIBB & SONS
New York City

Booth 27

E. R. Squibb & Sons has long been a leader in the development of new therapeutic agents for prevention and treatment of disease. The results of our diligent research are available to the medical profession in new products or improvements in products already marketed. At Booth 27, we will be pleased to present up-to-date information of these advances for your consideration.

STATE MEDICAL ASSOCIATION'S GROUP DISABILITY INSURANCE PROGRAM
Charleston, W. Va.
Booth 32

McDonough-Caperton-Shepherd-Goldsmith, administrators of the State Association Group Insurance Program, will have on hand brochures describing each of the programs officially sponsored by the Association. A representative will be available to answer questions regarding the operation of the plans available. The program has been in successful operation for over 18 years. Don't overlook the opportunity to obtain sound protection at low group rates.

Representatives: A. B. Daniel and J. Banks Shepherd.

THE STUART COMPANY
Pasadena, California

Booth 26

A cordial invitation is extended to all members and guests attending this meeting to visit the Stuart Company booth. Specially trained representatives will be in attendance to answer your questions on new products, developed in our modern laboratories, which have particular interest for the medical profession. Products featured are DIALOSE, DIALOSE PLUS, MYLANTA, MYLICON, STUART PRENATAL, STUART PRENATAL-F, MULVIDREN-F, MULVIDREN JUNIOR AND FERANCEE.

Representative: Barry R. Smth.

THE UPJOHN COMPANY
Kalamazoo, Michigan

Booth 23

Professional representatives of The Upjohn Company are eager to contribute to the success of your meeting. We are here to discuss with you products of Upjohn research that are designed to assist you in the practice of your profession. We solicit your inquiries and comments.

U. S. VITAMIN & PHARMACEUTICAL CORP.
New York City
Booth 25

The U. S. Vitamin & Pharmaceutical Corporation cordially invites you to visit its exhibit where ARLIDIN will be on display, as well as other leading pharmaceutical and nutritional products. Professional service representatives will be in attendance to welcome you and to be of help in answering any inquiries pertaining to the products on display, as well as any of their other products.

WYETH LABORATORIES
Philadelphia, Pennsylvania

Booth 47

Wyeth will feature . . .

New OMNIPEN® (ampicillin, Wyeth)—Anhydrous Ampicillin, inherently more stable than trihydrate form, offers wide - range activity of broad-spectrum antibiotics PLUS bactericidal action and relative safety of penicillin.

New SERAX® (oxazepam, Wyeth) Capsules—New specific for anxiety—notable for the wide separation of its effective and side-effective doses.

Full information is available at Booth No. 47.

Visit the Exhibits!

Plan to spend several hours in the Exhibit Center visiting the Industrial and Scientific Exhibits. They form an integral part of the over-all program and this is your opportunity to discuss with trained professional service representatives the new products and therapeutic developments.

Pharmaceutical houses spend millions of dollars annually in medical research. The trained medical representatives who will be in attendance at the meeting are interested in disseminating information about the new drugs and advanced techniques to practicing physicians.

Please take this opportunity to visit every booth and express your appreciation to our exhibitors for their continued cooperation and support.

ANNUAL REPORTS

Cancer Committee

The Cancer Committee of the West Virginia State Medical Association continued its function of acting as a Cancer Coordinating Committee for West Virginia during the past year. In this capacity it called together representatives of various groups interested in cancer on March 6, 1966.

A decision was made to expand the invitation to future meetings to include representatives of more specialty groups, and also nurses and pharmacists.

Dr. Alvin L. Watne of Morgantown proposed that refresher courses in proctoscopic examination be conducted at the University and at other centers in the State. This was approved by the Committee.

Miss Anne Rouse of the State Health Department's Cancer Control Division reported that more money would be available for the treatment of medically indigent cancer patients of the younger group when Medicare is started July 1. She also reported a plan for cytologic study of sputum in smokers and nonsmokers. This study was to be in the field of preventive medicine.

Mr. William Nichols of the American Cancer Society discussed facilities available for the rehabilitation of cancer patients.

Several other aspects of the cancer problem in West Virginia were also discussed.

Respectfully submitted,

Hu C. Myers, M. D.,
Chairman.

Philippi,
June 23, 1966.

Committee on Maternal Welfare

The meeting of the Maternal Welfare Committee of the West Virginia State Medical Association in conjunction with the Division of Maternal and Child Health of the West Virginia State Department of Health was called to order by the Chairman at the Daniel Boone Hotel, Charleston, West Virginia at 11:00 A.M. on May 22, 1966. Those present were Frederick H. Dobbs, M. D., Chairman, and the following members: Clarence H. Boso, M. D., Gates J. Wayburn, M. D., Edwin J. Humphrey, III, M. D., and Mrs. Jeanne Peccianti, R. N.

The Division of Maternal and Child Health of the West Virginia State Health Department was represented by Frederick H. Dobbs, M. D., Obstetric Consultant, and Mrs. Jeanne S. Peccianti, R. N., Obstetric Nurse Consultant.

The Chairman expresses his appreciation for the splendid cooperation of all members of the Committee and especially for the hard core of interested members who reviewed the abstracts of maternal deaths and formulated the policies, thus maintaining the high standard of obstetric practice which has been the mark of this Committee's work. The members attending the meeting represent the interested obstetricians who are professionally qualified to review the case abstracts, to understand the facts contributing to each maternal death and to make intelligent recommendations for the benefit of the interested physicians and the edification of the physicians who practice obstetrics in the State.

The splendid cooperation of the interested physicians is appreciated and it is a source of satisfaction that a physician having a maternal death will forward complete records, autopsies, consultations, laboratory procedures and operative records knowing that the Committee is interested in only one thing; that is, to increase the standard of obstetric practice among the physicians of the State. The data, thus obtained, is abstracted as a hypothetical case and the name of the patient, the physician and the hospital is confidential and not available to anyone except the Secretary and his departmental secretary.

In some maternal deaths a close chronological description of events, especially blood pressures, pulse, and respiration is necessary to understand a sudden demise. We find that the nurse's notes, the anesthetist's record, and a resident's description of events sometimes gives the clue as to the cause of death. The Record Librarians have cooperated splendidly in furnishing complete copies of the hospital records. All such data going to make up the abstract is treated as confidential material and kept in a locked file.

The Bureau of Vital Statistics, under the direction of Dr. N. H. Dyer and Mr. Paul Shanks, is the primary source of our maternal deaths. All death certificates of women in the childbearing age are checked by a special clerk who refers all certificates having any relation to pregnancy to the Secretary for his scrutiny. If the certificate is classified as a maternal death, the proper letters are written and a questionnaire is forwarded to the physician. In borderline cases, a letter is written for clarification.

The successful employment of the oral contraceptive method has resulted in a marked diminution of deliveries in the past several years. In West Virginia we are not only having fewer deliveries from the use of the "pill" but due to unemployment, we are gradually losing population, the greatest number of which are in the child-bearing age. Some small hospitals in urban areas have closed the obstetrical departments and utilized the beds for other patients. In others, clean gynecological patients are allowed in the obstetrical areas with token attempts made to maintain some sort of isolation of the parturient patient. The Committee

was presented with the problem of the small hospital having under 100 deliveries per year. The discussion was precipitated by the application of a small hospital which presented a plan to eliminate the obstetrical beds in the isolated area of the obstetrical department and utilize the beds (reserved for obstetrical cases alone) for occupancy by other medical and surgical cases. They planned to eliminate the newborn nursery by having "rooming-in" of the newborn with the mother. The delivery room would remain the same. The obstetrical patient would be admitted to a previously prepared private room and use this room as a labor room. When labor was completed, the patient would be moved to the delivery room for delivery. Following delivery, the patient and the newborn would be moved back to the private room, where both would remain until discharged. If the newborn infant developed a complication requiring special care and procedures, the adjoining private room would be available for treatment, where the infant could be isolated and given special care with either the floor nursing staff, or special nurses, depending on the severity of the complication.

The Committee agreed that this plan would utilize the beds for other admissions, but felt that the elimination of the nursery would lower the standards of newborn nursery care in the postpartum area. They felt that the nursery should be retained for the following reasons:

1) If the patient had a long and difficult labor, with a hard delivery, her convalesence would be retarded if the baby were constantly in her room and if the baby required extra attention. This would interfere with the patient's sleep and keep her in a state of constant vigilence if she were responsible for the full time care of the baby.

2) A premature baby would require special nursery care, especially in an incubator or isolette. This type of care would require more equipment and trained nursing personnel than would be available in a private room, which would be manned on an emergency basis.

3) A sick baby would require special medications, fluids, special formulas and special therapy. Fetuses requiring exchange transfusions, corrections of minor defects could not be adequately treated in a private room.

4) The question of an isolation nursery was brought up. It is usually in an isolated area, shut-off but adjacent to the newborn nursery. While isolation of the newborn is infrequent, it is a necessity when required.

The Standards and Guidelines for Family Planning and Child Spacing Clinics were presented and discussed. The legislature recently authorized the establishment and operation of one or more family planning and child spacing clinics under the supervision of a licensed physician for the purpose of disseminating information, conducting medical examinations and distributing family planning and child spacing appliances, devices, drugs, approved methods and medication without charge to indigent and medically indigent persons who are married and living with their spouses on request and with the approval of said licensed physician. These clinics can be established by local boards of health and offer oral contraceptives, foam jellies, vaginal jellies and cream alone, diaphragm with vaginal jelly or cream or the rhythm method due to religious belief, as methods of carrying out contraception. The bill was passed to authorize the clinics but no method was provided to finance such a program. The Committee agreed to the principles of the bill but felt it would not reach the indigent patient until the program had adequate financial assistance to maintain a high standard of professional medical care and adequate supplies of "pills" and jellies to maintain the program.

TABULATED ANALYSIS OF COMMITTEE'S WORK

The following tables contain the tabulated analysis of the work of the Committee for the current year and these studies are submitted for the information of and study by the members of the West Virginia State Medical Association.

The latest statistical survey for West Virginia between maternal deaths and births is for 1964. In that year there were:

Total Births	35,653
Maternal Deaths	14
Maternal Death Rate	.4

MATERNAL DEATHS, JULY 1, 1965—JUNE 30, 1966

I. Classification of Maternal Deaths Reviewed by Committee During the Period of July 1, 1965—June 30, 1966

Year	*Obstetric*	*Non-Obstetric*
1965-1966	6	2* (Medical)

*1 Rheumatic Fever with acute myocarditis; 1 Epilepsy.

II. Obstetric Deaths by Cause (1965-1966)

Cause of Death	*No.*	*% of Total*
Uterine Hemorrhage	2	33.3
1—Hemorrhage due to placenta praevia		
1—Hemorrhage and shock—laceration of uterus		
Cerebral Hemorrhage	1	16.6
Amniotic Fluid—Embolism	1	16.7
Acute renal failure	1	16.7
Anesthetic death	1	16.7
Total	6	100.0

III. Obstetric Deaths by Preventability (1965-1966)

Classification	*No.*	*% of Total*
Preventable by Physician	3	50.0
Preventable by Patient	1	16.7
Non-preventable	2	33.3
Total	6	100.0

IV. Obstetric Deaths by Place of Delivery (1965-1966)

Place	*No.*	*% of Total*
Hospital	5	83.3
Undelivered	1	16.7
Total	6	100.0

V. Obstetric Deaths by Race (1965-1966)

Race	*No.*	*% of Total*
White	6	100

VI. Obstetric Deaths by Age Groups (1965-1966)

Age Groups	*No.*	*% of Total*
15-19	0	0
20-24	2	33.3
25-29	1	16.7
30-34	0	0
35-39	2	33.3
40-44	0	0
44 plus	1	16.7
Total	6	100.0

VII. Obstetric Deaths by Parity (1965-1966)

Parity	*No.*	*% of Total*
Primapara	2	33.3
1-3	1	16.7
4-6	1	16.7
7 and over	2	33.3
Total	6	100.0

VIII. Obstetric Deaths by Weeks of Gestation (1965-1966)

Weeks of Gestation (Lunar Months)	*No.*	*% of Total*
Less than 28 weeks	1	16.7
28-33 weeks	1	16.7
34-39 weeks	2	33.3
40 weeks plus	2	33.3
Total	6	100.0

IX. Obstetric Deaths by Operative Procedure (1965-1966)

Procedure	Preventable	%	Non-Preventable	%
None	3	75	1	50
Caesarean Section	1	25	1	50
Total	4	100	2	100

X. Obstetric Deaths by Type of Consultation (1965-1966)

Type of Consultant	*No.*	*% of Total*
General Practitioner	3	Percentages cannot be calculated because some patients were seen by more than one consultant. But it is significant that only 16.7% had no consultation.
Neurosurgeon	1	
Urologist	1	
Pathologist	1	
Surgeon	1	
None	1	

XI. Interval Between Delivery and Death (1965-1966)

Time Interval	*No.*	*% of Total*
Under 1 day	2	33.3
1 day - 1 week	2	33.3
1 week plus	1	16.7
Undelivered	1	16.7
Total	6	100.0

XII. Outcome of Pregnancy in Obstetric Deaths (1965-1966)

Type of Outcome	*No.*	*% of Total*
Livebirth—full term	2	33.3
Livebirth—premature	1	16.7
Stillbirth	2	33.3
Not due	1	16.7
Total	6	100.0

XIII. Analysis of Obstetric Death Certificates (1965-1966)

	No.	*% of Total*
Death Certificate Correct and Complete	6	100

XIV. Autopsies done on Obstetric Deaths (1965-1966)

	No.	*% of Total*
Autopsy obtained	0	0
Autopsy not obtained	6	100
Total	6	100.0

Definitions

1. *Maternal Death*—The death of any woman dying of any cause whatsoever while pregnant or within six months of the termination of the pregnancy, regardless of the duration of the pregnancy at the time of the termination or the method by which it was terminated.
2. *Direct Obstetric Cause of Death*—A death resulting from complications of the pregnancy itself, to intervention elected or required by the pregnancy or resulting from the chain of events initiated by the complication or the intervention.
3. *Indirect Obstetric Cause of Death*—A death resulting from disease before or developing during pregnancy (not a direct effect of the pregnancy) which was obviously aggravated by the physiological effects of the pregnancy and caused the death.
4. *Non-Related Cause of Death*—A death occurring during pregnancy or within 90 days of its termination from causes not related to the pregnancy nor to its complication or management.
5. *Factors of Preventability (Avoidability)*—Preventability should be judged in an ideal academic sense. This concept involves three assumptions. First, the physician possessed all the knowledge currently available relating to the factors involved in the death. Second, by experience, he had reached a high level of technical ability. Third, he had available to him all the facilities present in a well-organized and properly equipped hospital. Because of the austerity of these criteria, it is more desirable to determine avoidable factors involved in the death, rather than to label the death as preventable. This allows more specific discussion resulting in better maternal care and reduction of obstetric causes of death.
6. *Factors of Responsibility*—Responsibility should be determined whenever possible and assigned as appropriate to the attending physician, consultant, midwife, hospital, patient, or any combination.

Factors

A. *Professional Factors*—These are concerned with cases where there appear shortcomings in diagnosis, judgment, management, and technique, and include failure to recognize the complication or evaluate it properly. They also include instances of injudicious haste, delay or timing of operative intervention, and failure to utilize currently acceptable methods of treatment. Finally, they would include services which were technically inept, and those failures which could have been averted by proper and timely consultation.

B. *Hospital Factors*—These are concerned with facilities, equipment, or personnel which are inadequate. In terms of modern obstetrics the hazards of delivery cannot be met successfully unless the hospital provides, (1) a separate, well-directed maternity section; (2) a blood bank; (3) competent 24-hour anesthesia service; (4) suitable x-ray facilities; and (5) adequate 24-hour laboratory facilities.

C. *Patient Factors*—These should be recognized, but never as an excuse for professional inadequacy. They are concerned with death resulting from a complication for which there is generally successful treatment but which the patient denied herself by delaying her initial visit to the physician, delaying obtaining medical care after the symptoms were obvious at a layman's level, or finally, by not following the advice and instructions of her physician.

D. *Undetermined Factors*—If because of inadequate evidence a clear-cut decision cannot be made, yet short-comings in care are apparent, it would be preferable to indicate that responsible factors are undetermined. An attempt should be made to determine preventability and to locate the responsible factors.

Analysis of Maternal Deaths

The Committee presents the following conclusions from the analysis of these maternal deaths:

1. *Uterine hemorrhage* again heads the list accounting for four of the eight deaths reported. There is an interesting variety of causes and it is in this category that the preventable factors are the most frequent. For example:

A. *Placenta praevia complicated by severe preeclampsia in an overage multipara.*

A 50-year-old Gravida 8 Para 7 was admitted to the hospital for the treatment of preeclampsia. She had a past history of cardiovascular complications with a heart lesion and a history of previous hypertension, albuminuria and renal stones with previous pregnancies. The present pregnancy was complicated by anemia, hypertension, renal complications, excessive weight gain, (32 pounds in 6 months), and the fact that she was a 50-year-old Gravida 8. The patient was admitted for the treatment of the preeclampsia and for the next 16 days, improved markedly until she went into active labor at 6½ months in the present pregnancy. With the onset of labor severe vaginal bleeding began and continued until her demise 7 hours later. The physician examined the patient and made the diagnosis of placenta praevia marginalis. The attending physician had consultation with a general surgeon and the hospital pathologist, but the patient died 7 hours after the beginning of labor and remained undelivered. There was no autopsy. She received whole blood and supportive measures but continued to go downhill until she expired.

B. *Acute Renal Failure caused from abruptio placentae and afibrinogenemia with hemorrhage.*

A 22-year-old Gravida 2 Para 0, Abortus 1, was admitted to the hospital with severe vaginal bleeding and passing large clots. She was 36 weeks in her second pregnancy and she had only one previous prenatal examination at 34 weeks. She gave a history of losing from 169 pounds to 121 pounds during the pregnancy (48 pounds) the cause of which was unknown. Bleeding began an hour before admission with large clots, and a half hour after admission the blood pressure dropped from 120/70 to 80/60. A cesarean section was performed immediately with the delivery of a stillborn fetus. The fundus was large, and mottled a dark blue and bleeding from the serosal surface, which confirmed the diagnosis of abruptio placentae but did not confirm the diagnosis of afibrinogenemia. In the immediate postpartum area the patient developed a complete renal shutdown and she never did pass any more urine after surgery.

Consultation with a urologist and several internists did not produce urine. On the fourth postoperative day she was removed to a medical center where she received hemodialysis, which was not successful. She remained completely anuric during the entire hospital course and she expired on the sixth hospital day at the medical center which was 10 days from the original hemorrhage and section. There was no autopsy.

C. *Hemorrhage the result of afibrinogenemia, amniotic fluid embolism, and abruptio placenta.*

A 28-year-old Gravida 5 Para 4, was admitted in active labor and as she had seven prenatal office visits, she was in good condition. Labor continued with slight dilatation for the next 8 hours when the contractions became irregular. She was given Nembutal gr 1½ which gave her some sleep until 6 hours later when she awakened and complained of severe backache, nausea with slight emesis. She remained 1 cm. dilated which revealed no progress all day. Two hours later she had a large amount of bright red bleeding and an examination revealed complete dilatation. The stillborn fetus was delivered in 15 minutes and after the placenta was expressed, she had a large amount of vaginal bleeding devoid of clots. The patient went into deep shock, with cyanosis, extreme dyspnea, restlessness and confusion. No blood pressure was noted and they could only feel the carotid pulse. She had a bloody frothy sputum exuding from the mouth and nares. Therapy was directed at replacing the lost blood and to reestablish her ability to clot. Before fibrinogen could be given, she expired. There was no autopsy.

D. *Hemorrhage from laceration of the uterus*

A 37-year-old grandmultipara was admitted at 30 weeks in her eleventh pregnancy with severe vaginal bleeding. She had three previous admissions in July, September, and November for the same symptom. The fourth admission was in the later part of November, and they waited two days before she was put into labor with pitocin drip. Labor was completed in 7½ hours but the vaginal bleeding continued all through this hospital stay and continued with labor and delivery of the placenta. The cervix was inspected and the 2½ inch lacerations were sutured. She received 17 pints of whole blood in the next 24 hours but the physician and his consultant felt that the blood pressure was always too low to risk a hysterectomy.

E. *Asphyxia due to an obstructed airway. (Anesthetic death)*

A 35-year-old Gravida 4 Para 3 was admitted to the hospital in active labor. The progress of labor was not satisfactory so a Pitocin drip was started, which stimulated labor and required analgesics in a half hour after the drip was started. An hour after the Pitocin was started, she was completely dilated and removed to the delivery room and when the nurse anesthetist administered chloroform, she had poured only 10 drops when the patient suddenly turned black and expired. Forceps were immediately applied and the full term fetus delivered, and still survives. The patient expired at the same time the fetus was delivered. The pitocin drip was allowed to run 10 minutes after the patient had expired. She received stimulants but there was no response to any therapy. Death occurred 12 hours from the

beginning of labor, an hour and 45 minutes after hospital admission and an hour and 15 minutes from the beginning of her pitocin. There was no autopsy.

F. *Death due to cerebral hemorrhage.*

A 21-year-old primigravida was admitted to the hospital at 39 weeks in her first pregnancy with the history of waking out of a sleep, screaming with severe headache and pain, and went into a comatose condition from which she never did recover. She had only two prenatal office visits, one at 31 weeks when her blood pressure was 120/80 and urine negative and a weight gain of 7 pounds with her weight 162 pounds. At 36 weeks, she had a blood pressure of 150/100, had gained 6 pounds in 5 weeks, and had pitting edema, and a one plus albuminuria. *Two weeks later* she wakened with this severe pain and went into a coma. The blood pressure at that time was 180/100 and she had a marked 3 plus generalized edema.

She was admitted with a blood pressure of 128/82, the pupils were dilated and non-reactive and the patient was areflexic without nucal rigidity. Three hours after admission the patient developed hyper-reflexia, first on the left then bilateral, then cyanosis, then collapse. The blood pressure at this time was 240/140. She was in complete collapse with no breathing and a thready pulse. Artificial respiration was instituted and a cesarean section was performed in bed, and a living fetus was delivered which survives. The patient was transferred to an intensive care unit and placed on a respirator and cardiac monitor and she continued in this vegetative state for seven days when she expired. There was no autopsy.

2. Two maternal deaths from non-obstetric causes were abstracted with the following results:

G. *Rheumatic heart disease with acute myocarditis.*

A 44-year-old female, a Gravida 7 Para 6 was admitted to the hospital at 6 months in her present pregnancy, in shock, with cyanosis and rapid atrial fibrillation. The patient had 6 prenatal office visits which were all within normal limits until the last one when she had a one plus albumin in the urine specimen. Her weight gain was 20 pounds and the blood pressure averaged 140/80. She had mild asthma all her life but no history of heart disease or hypertension. The family physician had cared for this patient for many years and delivered at least 3 full term pregnancies without incident. At no time during these years was there any evidence of a heart lesion or any break in her cardiac rhythm.

Four days before her admission, the patient had difficulty in breathing, increasing shortness of breath associated with weakness, nausea and vomiting. The physician treated her at home but she developed difficulty in walking and was admitted in shock. Immediate consultation with a cardiologist and an internist who made the admitting diagnosis of paroxysmal, rapid fibrillation, atrial; and early cardiac decompensation with cyanosis. During the next eight days, the patient was digitalized, and given many courses of cardiac drugs and countless laboratory examinations. She improved for a time and became controlled. Her pulse dropped from 195 to 80 but in the last hour of her life, she complained of sternal discomfort, the pulse became weak and irregular and she expired. An autopsy was performed:

The autopsy findings were:

1. Old healed endocarditis of the mitral valve with stenosis of the orifice. (Rheumatic fever in type)
2. Dilatation of the left atrium and chronic cor pulmonale secondary to 1.
3. Acute myocarditis (non-rheumatic in origin).

H. *Epilepsy with a possible amniotic fluid embolism.*

A white female, a Gravida 1 Para 0 died very suddenly at home with the diagnosis of amniotic fluid embolism and the case complicated by a history of epilepsy. She was 2½ months in her first pregnancy and had had only one prenatal office visit to her family physician. The hemoglobin was 80%, the blood pressure 130/82 and the urine specimen negative for albumin, sugar and casts. She was taken suddenly ill at home and expired almost immediately with convulsions. There was no autopsy. The physician signed the death certificate as "amniotic fluid embolism" but the Committee felt the epilepsy was the cause of her demise, accentuated by the pregnant state.

Respectfully submitted,

F. H. Dobbs, M. D.,
Chairman

Charleston,
June 17, 1966.

Medical Scholarships Committee

Your Committee on Medical Scholarships met in Morgantown on April 16-17. Twelve applicants were interviewed Saturday evening and Sunday morning and the two selected were James C. Bosley of New Creek, Mineral County, and Earl H. Eye, Jr., of Deer Run, Pendleton County.

A business meeting was held on Saturday afternoon at which time a critical review and discussion was entered into by all the Committee of the changes that have occurred in scholarship needs since the inception of our program in 1958.

When our program was instituted, neither the AMA nor the government had come into the picture. We felt it was a definite obligation of the West Virginia State Medical Association to help students interested in rural practice. We at that time also appreciated that the rural community, in order to attract a graduate to locate in that setting, must also offer reasonable attractions for the family of a physician, such as churches, schools, roads, cultural advantages, etc.

The applicants are always very much interested in rural practice when they are interviewed, but during the course of their medical education and internship their enthusiasm has a tendency to waver. Probably if the University had a chair in General Practice their freshman dedication might be retained.

Our first scholarship recipient, Dr. Larry Hemmings, has definitely decided to specialize and is now in the process of repaying his indebtedness to the Association.

Our second graduate, Dr. Terry Tallman, has not definitely decided to fulfill his contract; he will wait until he returns from England to make a final decision.

I do not feel that we should re-evaluate our program for at least three or four more years. If our recipients do not wish to fulfill their contracts then it will be treated as a loan with no loss to the Association. At least it will give help to a deserving student to obtain his medical education.

As you know, we give $4,000 each year to the University Loan Fund to help upper-classmen in medicine if they are confronted with a sudden financial crisis.

This we feel is an excellent part of our program, for it will stop any waste of time in obtaining his degree.

Quick Recap of the Over-All Scholarships Fund Shows:

Regular Fund (Or Fund No. 1)	
Cash on Hand as of April 30, 1966	$ 7,980.68
Bonds at Maturity	6,000.00
Investments	6,000.00
	$19,980.68
Charles Lively Memorial Scholarship Fund (Or Fund No. 2)	
Cash on Hand as of April 30, 1966	$13,319.15
Bonds at Maturity	1,000.00
	$14,319.15
Total Amount of Scholarship Funds As of April 30, 1966	$19,980.68
	$14,319.15
	$34,299.83

Respectfully submitted,

J. P. McMullen, M. D.,
Chairman.

Wellsburg,
June 15, 1966.

Medical Aspects of Sports

Two years ago your Committee recommended to the High School Football Coaches Association of West Virginia that a one to two week preseason conditioning program be instituted for football. They received this enthusiastically and the program was started in the Summer of 1965. It was then approved by the Secondary School Activities Commission and the High School Principals Association.

A survey of this program was made among football coaches this Spring and the response was overwhelming. Many physicians may wish to know what the results were in the first year of this program.

1. Did you have a preseason conditioning program? Yes (119), No (9).
2. If so, did you think the result was good? Good (100), Fair (19).
3. How many sessions per day? One (82), Two (37).
4. Approximate length of each session? ½ hour (1), One hour (39), Two hours (63), Three hours or more (2).
5. Were your injuries at the beginning of the season greater or less? Same (4), Greater (5), Less (106).
6. Did you see improvement in the awkard boys? Yes (107), No (10).
7. Did fewer quit the squad? Yes (87), No (28).
8. Do you believe the program should be continued? Yes (114), No (2).
9. Would you prefer a one-week period instead of two? Yes (35), No (78).

Initially this program has proved of great benefit. It will be continued. From the results of this preliminary survey it seems that a two-hour session gave the best results.

Your Committee Chairman presented these findings to the State High School Coaches Association meeting in Huntington, March 20, 1966. At that time it was recommended also since head and neck injuries are the most serious a recommendation on the proper fitting of headgear as recommended by the University of California of Los Angeles team physician and trainer be followed. A question and answer period was held and your State Committee received very fine plaudits for its recommendations and help. It was also reported that your Committee Chairman will present a paper on the role of the State Medical Aspects of Sports Committee at the American Medical Association Clinical meeting in November, 1966, at the AMA's Annual Conference on the Medical Aspects of Sports.

Also during the year your Committee received recognition in the *Medical World News* in its endeavor to furnish proper medical attention for high school athletes.

At a meeting in Charleston in May, the Committee recommended that a questionnaire be sent out to the high schools of West Virginia concerning their medical coverage. At this time this report is not complete; however, a cursory examination of the questionnaires received shows that a majority of the high schools are receiving adequate local coverage and in only a few instances were there any complaints. Your Committee will investigate these.

It was reported to your Committee by Mr. Gordon Eismon, Executive Secretary, West Virginia Secondary School Activities Commission, that the insurance coverage is much better now than it was several years ago. The American Medical Association publishes a considerable amount of material on athletic injuries, and your Committee will seek to have copies sent to team physicians and other interested doctors in the State.

It was suggested that the President of the State Medical Association be asked to invite one of the members of the State Dental Society to sit with this Committee next year.

It was also recommended that a standard physical examination type of questionnaire be sent to each high school for their adoption as recommended by the AMA Medical Aspects of Sports Committee.

Respectfully submitted,

Richard W. Corbitt, M. D.
Chairman.

Parkersburg,
June 30, 1966.

Medical Education and Hospitals

Your Committee on Medical Education and Hospitals conducted studies in two areas during 1966: (1) the possible establishment of a second two-year medical school in the state, and (2) postgraduate medical education for practicing physicians.

The Committee studied the medical school issue at length and concluded that a second medical school is not feasible at this time. As a substitute means of producing more medical school graduates, the Committee recommends doubling the present enrollment

of the West Virginia University School of Medicine and broadening the medical education of the students by establishing supplemental instruction during the clinical years in areas of the state in addition to Morgantown.

At a meeting on February 20, 1966, in Charleston, the Committee unanimously adopted the following statements:

1. "This Committee regards the establishment of another independent two-year medical school as unfeasible and (recommends) that attention be directed instead toward expanding the present facilities of the West Virginia University School of Medicine so as to double its present enrollment and production of graduates within the next few years."
2. "In order to render the highest standard of medical care to the people of West Virginia, the Committee advocates: (1) broadening the medical education of our medical students by the WVU Medical Center in cooperation with the State Medical Association by establishing supplemental instruction in the clinical years in other geographical areas in our state, (2) coordinating and improving graduate intern and resident programs, (3) providing increased postgraduate education for the practicing physicians of our state, and (4) rendering more attractive the practice opportunities for the new physicians in our state."

At a meeting in Charleston on May 1, the Committee laid the groundwork for a broad medical education program for practicing physicians. In the preliminary planning, the state was divided into eight geographical areas for the purpose of postgraduate education. Medical Education Workshops would be centered around Morgantown (Area 1), Wheeling (Area 2), Martinsburg (Area 3), Parkersburg (Area 4), Charleston (Area 5), Huntington (Area 6), Beckley (Area 7) and Bluefield (Area 8). It is the intent of the Committee that educational programs be conducted in a number of communities in each area.

Suggested as educational topics to start are cardiovascular disease, dermatology and gastroenterology. Training is to be hospital-oriented.

A member of the Committee from each Area was appointed to draft a plan for postgraduate education in his respective region. These proposals were to be submitted and discussed at another meeting of the Committee in July.

Respectfully submitted,

Pat A. Tuckwiller, M. D.
Chairman.

Charleston,
June 20, 1966.

Mental Health Committee

The Mental Health Committee during the year 1965-66 held several meetings to discuss and formulate plans for assisting the State Department of Mental Health in its current programs. At these meetings new legislation was discussed and projects were scrutinized through the cooperation of Doctor Bateman, Director of the Department. Where policy matters and newer ideas of administration were concerned, the Committee took a positive stand to endorse Doctor Bateman's efforts in these directions.

As usual, members of the Mental Health Committee have served this year, like they did in years past, in an advisory capacity to the State Department of Health and to other state and voluntary agencies. This type of community participation has enabled many new and local projects to be started.

In every respect the mental health activities of the State of West Virginia are progressing according to plan and with considerable force now that the preliminary work of the state-wide plan has been completed.

Respectfully submitted,

William B. Rossman, M. D.
Chairman.

Charleston,
June 20, 1966.

The West Virginia Medical Journal

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The Electrocardiogram in Heart Block*†

Desmond Allen, Judith Dennis, B. Sc., and Robert J. Marshall, M. D., M. R. C. P.

Introduction of new methods of treatment, both pharmacological and electronic, has led to a remarkable growth of interest in the problem of heart block. Satisfactory management of patients with heart block is, however, dependent on recognition of the precise nature of the underlying functional disturbance. The aim of this paper is to illustrate some of the electrocardiographic phenomena selected from our recent experience in a series of 56 cases referred to this Center.

Classification of Heart Block

In first degree block the PR interval is prolonged to greater than 0.20 second. In the electrocardiogram shown in Figure 1 it is 0.45 second.

In the example of second degree block (Figure 2) there is one QRS complex for every two P waves and the PR interval is constant (0.20 second); 2:1 atrioventricular block is said to be present. Sometimes there may be a more complex relationship: for example, the ventricle may

The Authors

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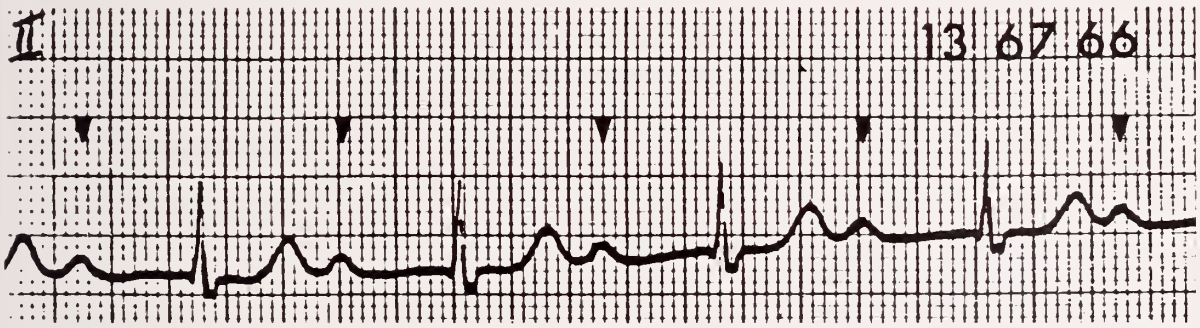


Figure 1
First degree heart block. PR interval 0.45 second.

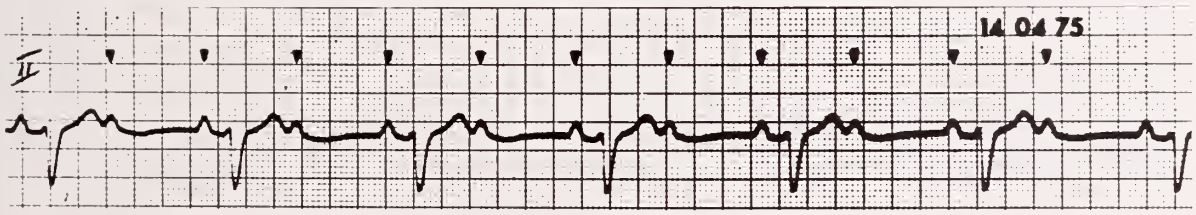


Figure 2
Second degree heart block with 2:1 ventricular response.

respond to every second and every third atrial complex, respectively.

Another variant is the Wenckebach phenomenon, (Figure 3). In the upper two strips of this continuous record, the QRS complex is occurring in response to each second P wave, but there is a lengthening of the PR interval from one ventricular cycle to the next (0.21, 0.33, 0.83; 0.21, 0.64; 0.21, 0.30, 0.58 second). The irregularity of the RR intervals (1.86, 2.29, 1.94, 2.13, 2.23, 1.84, 2.06 second) excludes the possibility that this is third degree (complete) heart block. In the bottom strip, atrioventricular conduction is somewhat more efficient; although second degree block still is present, there is no sequential lengthening of the PR interval, which is 0.24 second in each cycle. The bottom strip also illustrates the ventriculophasic arrhythmia. The PP intervals that enclose a QRS complex are consistently shorter (0.82 to 0.88 second) than those that do not (0.96 to 1.02 second). This positive chronotropic effect is unrelated to the phases of respiration. It probably is due to a mechanical effect of ventricular activation on the rate of discharge of the sinus pacemaker.[1]

The Mobitz type, a less common variant of second degree block, is characterized by the dropping of a single ventricular beat at intervals to give a 3:2, 4:3, 5:4, etc. ventricular response to the atrial impulse, in the absence of a sequential prolongation of the PR interval. Figure 4 shows an example. The patient had a recent diaphragmatic myocardial infarct complicated initially by complete heart block, with Stokes-Adams attacks. The conduction mechanism gradually improved under the influence of treatment with adrenocortical steroid hormones and potassium-depleting drugs, and the Mobitz type of block was seen prior to the resumption of normal conduction. The PR interval is constant (0.16 second), but there is no ventricular response to each third P wave. As in Case 1 of Kaufman et al.[2] who also had a recent diaphragmatic infarct with a 3:2 Mobitz block, the QRS complex had the pattern of right bundle branch block.

In third degree, or complete, heart block, the atria and ventricles are controlled by independent pacemakers. Thus, the P and QRS complexes have only a random relationship to each other (Figure 5). The ventricular rate is much

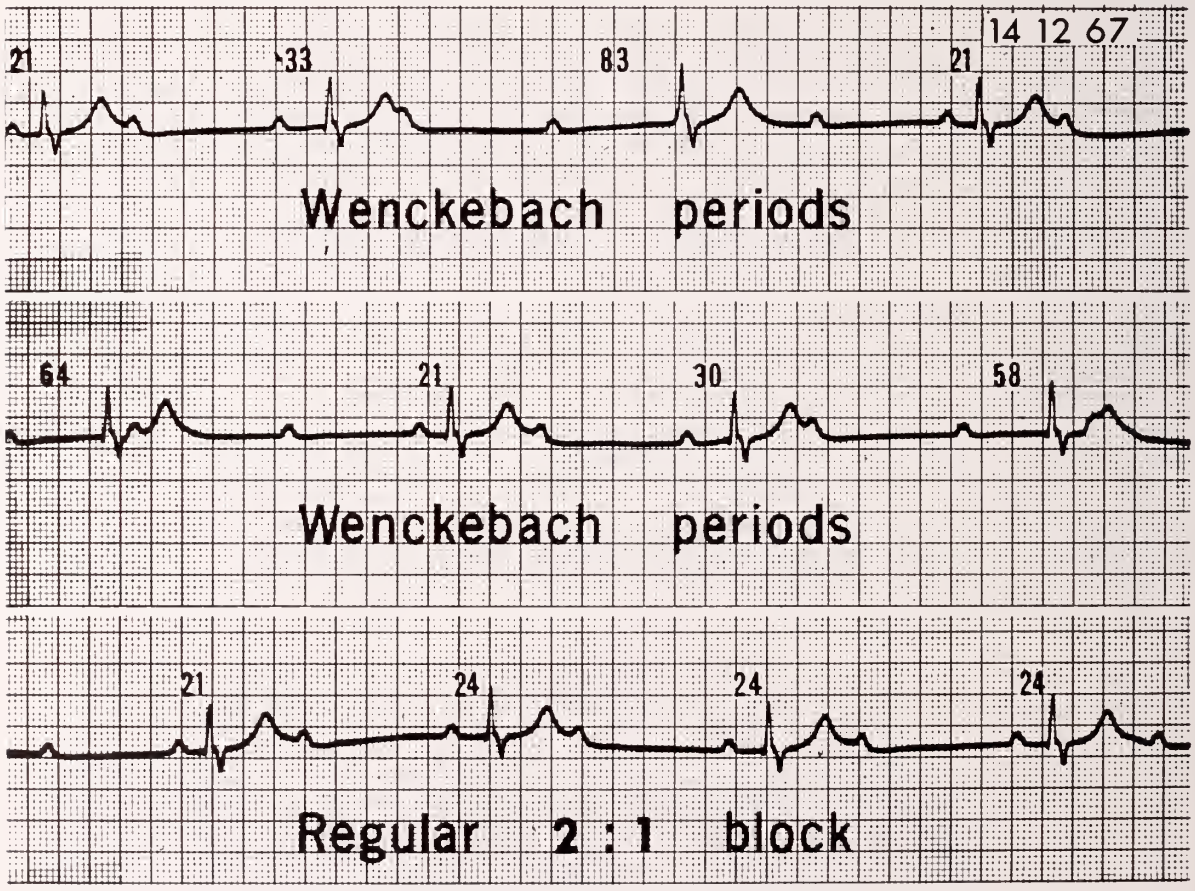


Figure 3
Wenckebach periods. For discussion, see text.

slower than the atrial rate. In congenital complete heart block the ventricular rate is faster than in acquired block, and it is more responsive to physiological stimuli such as exercise and to chronotropic drugs such as Isoproterenol. The QRS complexes may be of normal pattern and duration, if the idioventricular pacemaker is situated above the bifurcation of the bundle of His. When the ventricular pacemaker is distal to the common bundle, the QRS complex is prolonged and bizarre, simulating that in bundle branch block. A broad and bizarre QRS complex also is present when a high ventricular pacemaker is associated with a true bundle branch block.

Variability of Degree of Block

For purposes of description it is convenient, as we have done, to describe the various degrees of heart block as though in a given patient they were fixed and immutable. Often they are.

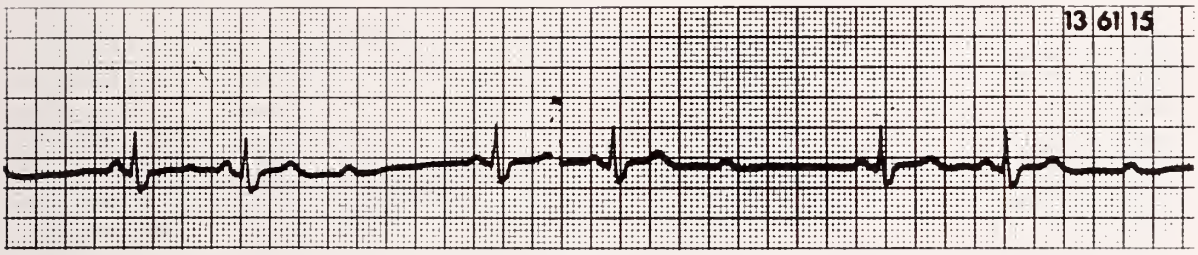


Figure 4
Mobitz variant of second degree heart block.

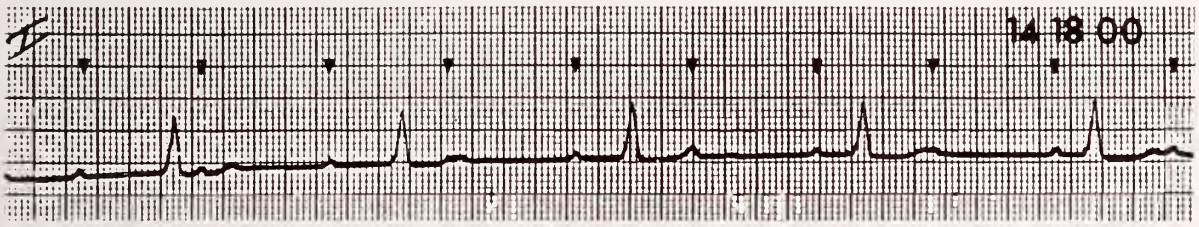


Figure 5
Third degree (complete) heart block.

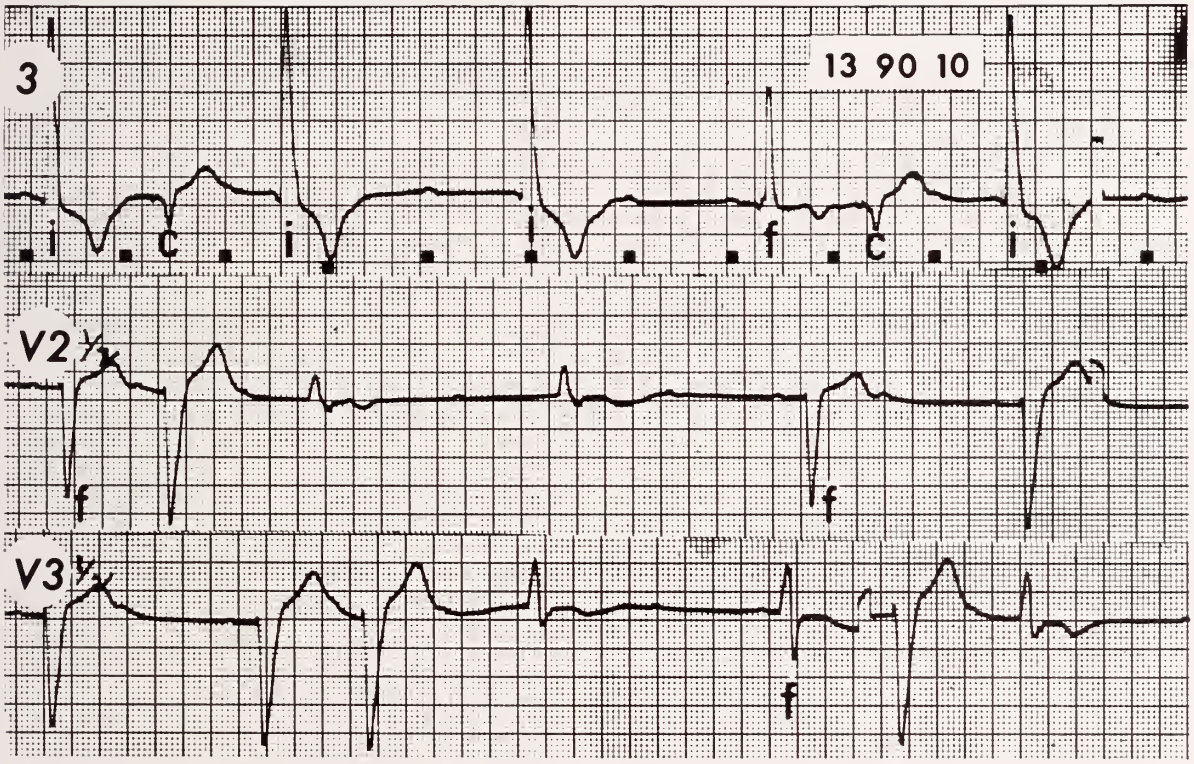


Figure 6
Alternating 1st.° (PR 0•23, RR 0•76), 2:1 (RR 1•53) & 3rd.° (RR 1•72) block. i: idioventricular, c: conducted, f: fusion beats.

In other cases, the degree of block varies from moment to moment, and even from cycle to cycle. A striking example of such variability is shown in Figure 6. In the upper strip (lead 3) the timing of the P waves is indicated by black squares. The first, third, fourth and seventh QRS complexes (i) are identical and are temporally unrelated to P waves; they are idioventricular complexes with RR intervals of 1.72 second. The second and sixth QRS complexes (c) are conducted from preceding P waves, with a slightly prolonged PR interval of 0.23 second. The fifth complex (f) is a fusion beat, formed by the amalgamation of the fourth idioventricular complex of the series with the ventricular complex resulting from conduction of the eighth P wave. In the middle strip, the first and second QRS complexes result from conduction of successive P waves (first degree block); the fifth and sixth complexes show second degree block, being

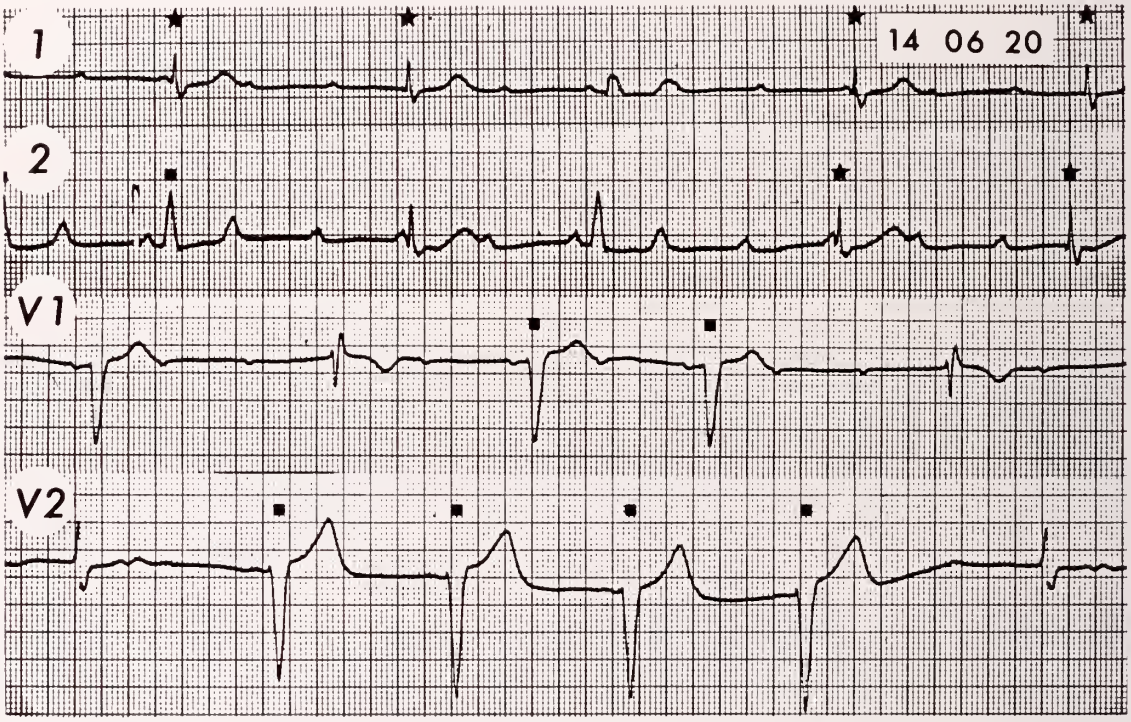
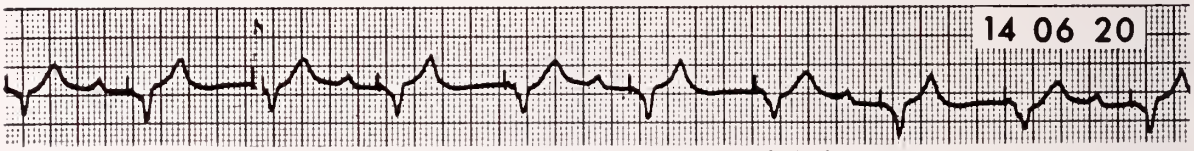
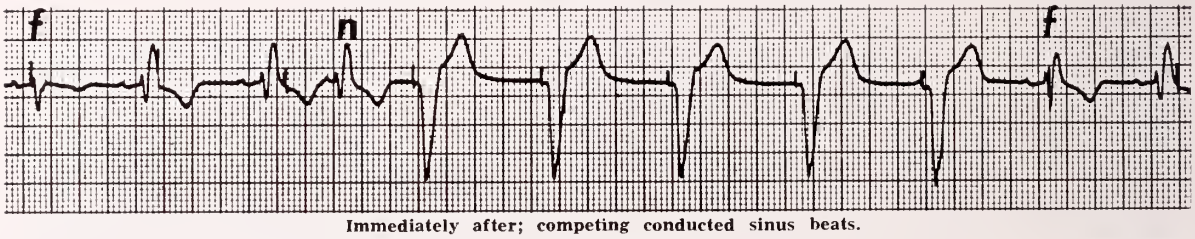


Figure 7
Alternating complete heart block (*-*, with R-R interval 1•72 sec.) and 2:1 AV block with LBBB (■-■, with R-R interval 1•31 sec.).

Figure 8



Before operation; ventricular response to electrode.



Immediately after; competing conducted sinus beats.

Electrode removed; sinus rhythm, few nodal beats.

separated by a nonconducted P wave; the third and fourth complexes show third degree block. In addition, measurement of time intervals confirms the fact that the first and fifth complexes are fusion beats that result from the coincidence of slightly positive idioventricular complexes with the strongly negative conducted complexes. The lower strip further exemplifies the cycle-to-cycle changes.

Figure 7 illustrates another example of repetitive changes in the pattern of block. Cycles of second degree block with 2:1 conduction (RR interval 1.31 second) and left bundle branch block alternate with cycles of third degree block (RR interval 1.72 second). Where two or more of the former occur in succession they are indicated by black squares, and where two of the latter occur in succession they are indicated by black asterisks. The patient was a man aged 72 years, who gave a history of transient attacks of right-sided hemiparesis for the previous year, and who had a more severe attack three weeks prior to admission. The arterial blood pressure was 220/120 mm. Hg., the pulse rate was 40 per minute, and there were bruits over the carotid arteries. Following transfer to the Neurosurgical Service he was found to have a large left-sided meningioma.

A bipolar endocardial catheter pacemaker was inserted, and consistent ventricular capture occurred at the pre-set rate of 67 per minute (upper strip, Figure 8). Towards the end of the operation, after the tumor had been removed, the anesthesiologist noted that the pulse had become slightly irregular. An electrocardiogram taken at the end of the operation (lead V_1, middle strip, Figure 8) showed that normal atrioventricular conduction had been restored (second, third, and eleventh QRS complexes) with the pattern of right bundle branch block. The fifth through the ninth QRS complexes occurred in response to the stimulus from the endocardial pacemaker; the first and tenth QRS complexes (f) were fusion beats, due to coincident ventricular capture by the normal conduction mechanism and by the endocardial pacemaker; the fourth QRS complex (n) resulted from a premature high AV nodal beat. Following removal of the endocardial pacemaker, a normal pattern of conduction was interrupted only by the occurrence of occasional premature nodal beats (lower strip, Figure 8).

The relief of heart block in this patient coincided with removal of a large intracranial tumor. It is well known that intracranial lesions such as subarachnoid hemorrhage and procedures such as pneumoencephalography can lead to many different abnormalities in the electrocardiogram. Heart block is one of the least common of these abnormalities; it has, however, been documented in occasional patients with severe head injuries.[3] Presumably it results from prolonged and excessive corticovagal stimulation of the heart.

Retrograde Conduction

In a few patients with complete heart block, occasional idioventricular complexes are closely followed by inverted P waves. Originally it was suggested that the lower parts of the atria were mechanically stimulated by the early contraction of the ventricles. Current evidence, however, favors the view that true retrograde conduction may be retained after orthograde (forward) conduction has been lost, possibly because different pathways may exist for forward and backward conduction.

In Figure 9, all P waves are upright (black squares) with two exceptions (arrows). The second QRS complexes in both strips are immediately followed by inverted P waves, which occur 0.08 second before the next upright P wave would have been expected. Retrograde P waves were also observed during temporary endocardial pacemaking and subsequent to surgical implantation of a pacemaker. They occurred, however, only when the interval between the responsible QRS complex and the P wave that preceded it was 0.42 second or greater; with shorter intervals, retrograde conduction was presumably blocked by the refractory state of the atrial muscle. Similar phenomena were seen in another patient, both before and after insertion of temporary and permanent pacemakers.

Stokes-Adams Attacks

The course of some patients is punctuated by sudden attacks of syncope or convulsions (Stokes-Adams attacks) due to a sudden decrease or cessation of cardiac output, and hence of cerebral blood flow. These most commonly occur either at the time of transition from second to third degree heart block, or during the course of established third degree heart block. There are several different mechanisms.

Figure 10 is from the case of a patient who developed intermittent conduction defects following repair of a high ventricular septal defect. The upper strip shows a few complexes of sinus tachycardia with normal AV conduction and aberrant intraventricular conduction (slurred S wave). This is suddenly interrupted by slowing of the rate of discharge of the sinus node and

by ventricular asystole. The sinus rate gradually increases, ("warming-up" phenomenon), but in the middle strip there is only one QRS complex, preceded by a prolonged PR interval (0.38 second). The lower strip again shows sinus tachycardia with normal AV conduction that is suddenly interrupted by atrial and ventricular asystole (cardiac standstill).

Ventricular asystole is likely to occur when an artificial pacemaker that has been driving the heart for some time is suddenly switched off. This is seen even in some patients with no previous history of Stokes-Adams attacks, who are being paced because of a critically low cardiac output. We saw it occur on one occasion during an intravenous infusion of Isoproterenol, in the case of a patient who had a history of Stokes-Adams attacks (Figure 11). Strip 'a' shows complete heart block. Strip 'b', obtained during Isoproterenol infusion, shows restoration of AV conducation, with a prolonged PR interval (0.24 second); it is of interest that in the cycles following the two atrial premature contractions ('x'), the PR interval is normal, by virtue of the compensatory pauses. As the infusion continued, ventricular asystole occurred. In strips 'c' to 'g', which are continuous, the sinus pacemaker continued to discharge, although its rate slowed as the patient became unconscious. Increasing baseline tremor resulted from a convulsion. There

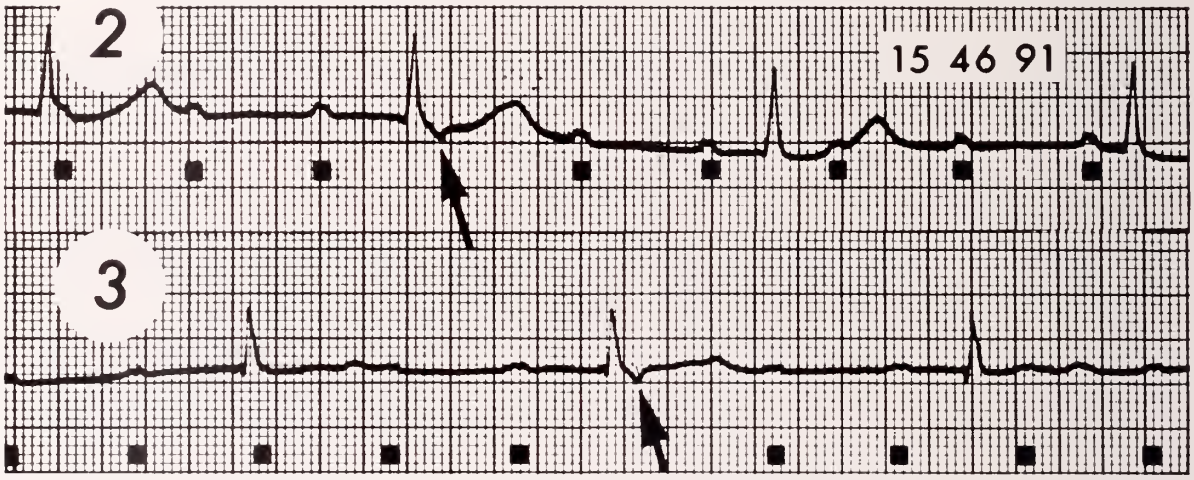


Figure 9
Retrograde conduction to the atria in complete AV block.

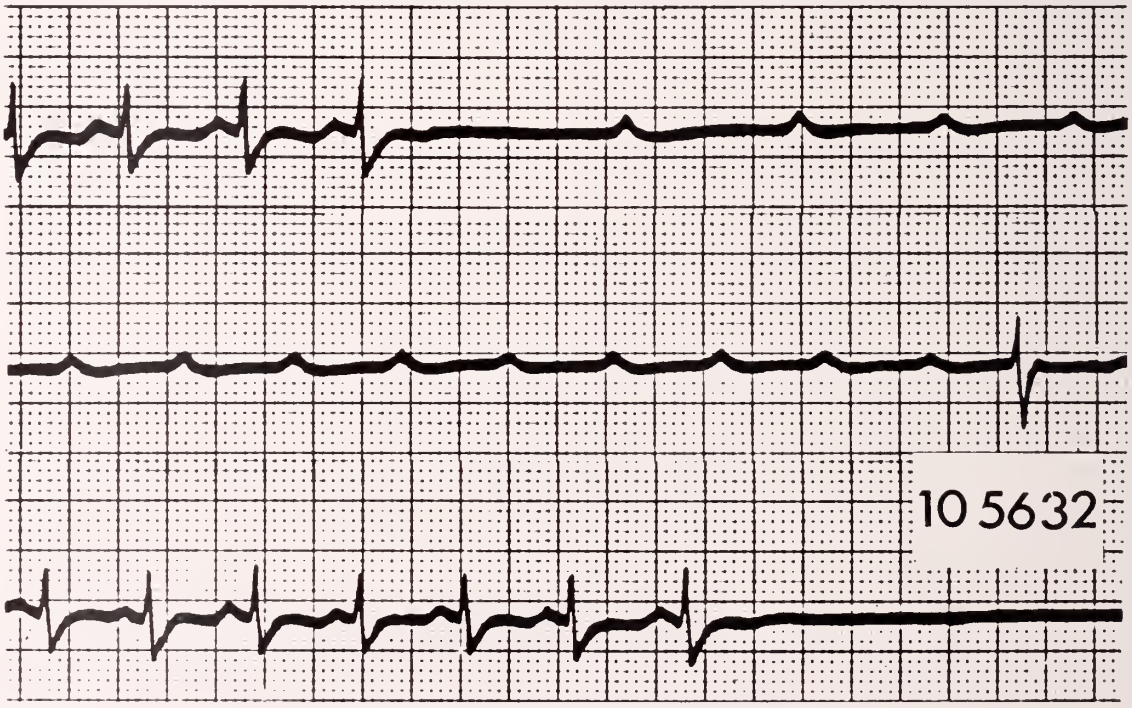


Figure 10
Heart block following repair of VSD (continuous tracing).

were only very occasional multifocal ventricular escape beats, until AV conducation suddenly was restored. The patient subsequently lapsed into complete heart block and had a permanent pacemaker inserted. Soon after surgery, presumably as a result of improved myocardial blood flow, he regained his own conduction mechanism and, since then, his ventricle has been under the control both of his own conduction system and the electronic pacemaker. He has recovered from a subsequent myocardial infarction, has had no further Stokes-Adams attacks, and is in full employment.

Stokes-Adams attacks may result also from transient spells of ventricular tachycardia, ventricular flutter or ventricular fibrillation. We have seen instances of all three of these arrhythmias.

Figure 12 shows the sudden onset of ventricular fibrillation in a patient with complete heart block. An example of ventricular tachycardia is shown next (Figure 13). As in this example, the arrhythmias usually are preceded by single or multiple ventricular ectopic beats. The patient whose electrocardiogram is shown here experienced up to 40 convulsive spells daily for many weeks prior to insertion of a pacemaker; in the subsequent 3½ years, she has had no such episodes. Yet another cause is an extremely slow idioventricular rate. The slowest rate we have seen is 15 per minute. In such cases the cardiac output and the cerebral blood flow are clearly inadequate to maintain consciousness.

Electrocardiographic Pattern During Pacemaking

Discussion of the many interesting electrocardiographic phenomena that may occur during artificial pacemaking is beyond the scope of this paper. In view of the increasing numbers of patients, however, who are having these devices inserted, it is well for physicians to be aware of the usual electrocardiographic features.

All pacemakers emit currents that are picked up by the electrocardiograph. In view of the brief duration of the impulse (1-2 milliseconds), only an extremely thin line is recorded, which is negative in some leads and positive in others. This impulse is immediately followed by a QRS complex. If the electrodes are in the right ventricle (catheter pacemaker) there is delayed

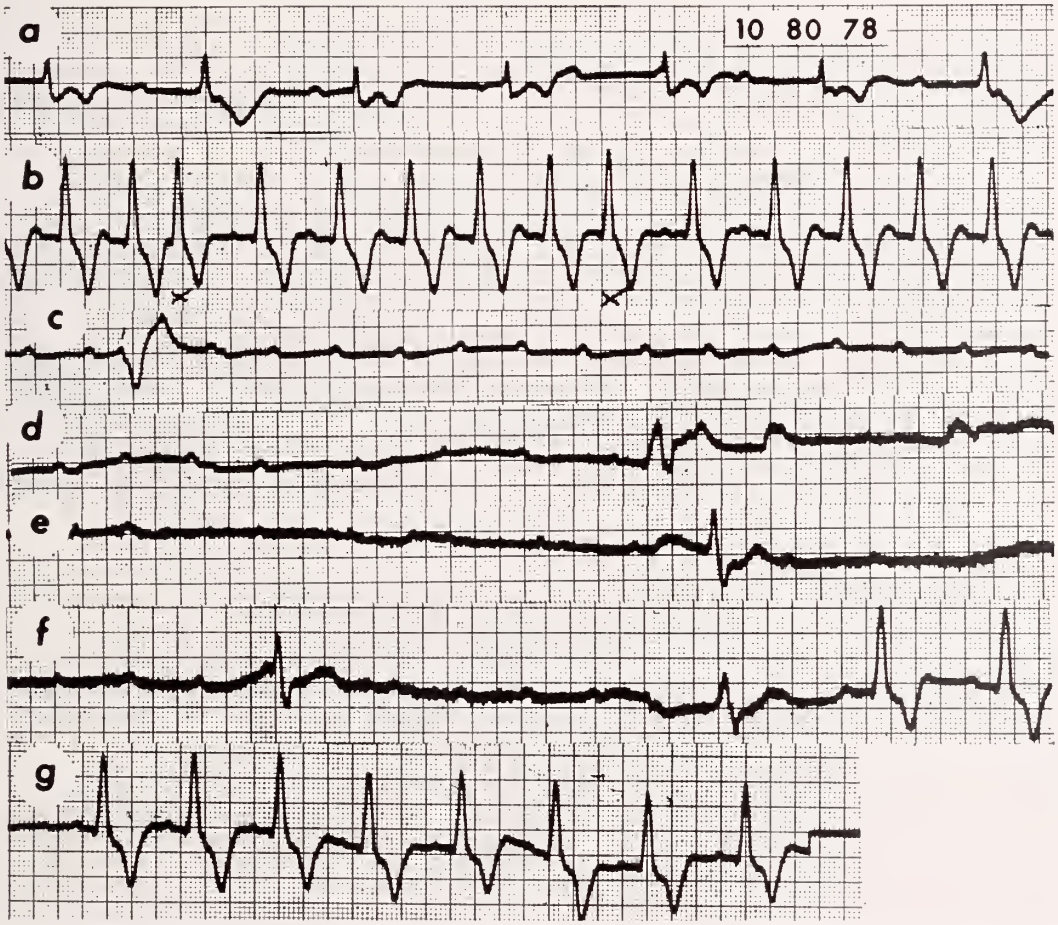


Figure 11
a: complete AV block. b: isuprel infusion then restores conduction. c-f: Stokes-Adams episode.

activation of the left ventricle and the QRS pattern is similar to but not identical with that of classical left bundle branch block. If they are in the left ventricle (permanent surgical pacemaker), the pattern of right bundle branch block is simulated.

Figure 14 shows a sinus rate at 88 per minute (tall upright P waves). There is an input from the artificial pacemaker at 64 per minute that is seen as a 2 mm. negative deflection (retouched for clarity) immediately preceding the broad (0.16 second) QRS complex. The ventricle is consistently captured by the artificial pacemaker and, because of the persistence of complete heart block, does not respond to the P wave. This is the pattern most often seen.

Some patients, however, regain their own conduction mechanism subsequent to the implantation of a pacemaker. An unusual example is shown in Figure 8 (middle strip). In such cases, there is competition for control of the ventricle between the patient's own conducting system and the artificial pacemaker, which acts as a parasystolic focus (iatrogenic parasystole). In Figure 15, the 3 mm. upright 'blips' from the artificial pacemaker are readily seen; the P waves are indicated by arrowheads for greater clarity. The respective rates are 71 and 80 per minute. The

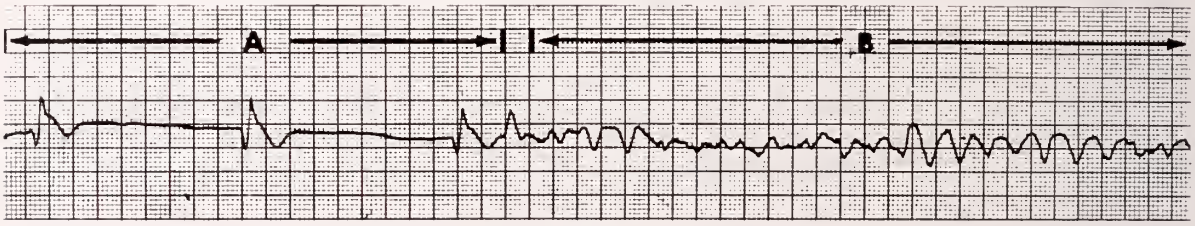


Figure 12
A. Complete heart block. B. Ventricular fibrillation.

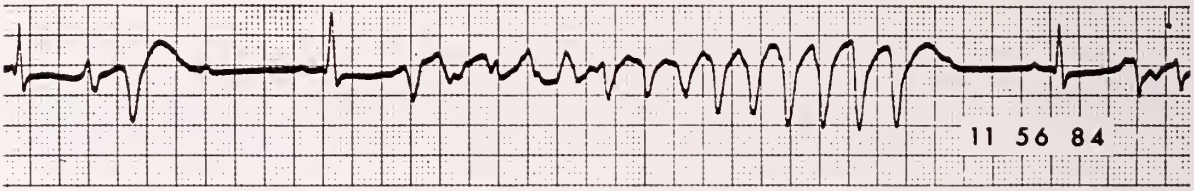


Figure 13
Heart block with repetitive ventricular tachycardia causing Stokes-Adams attacks.

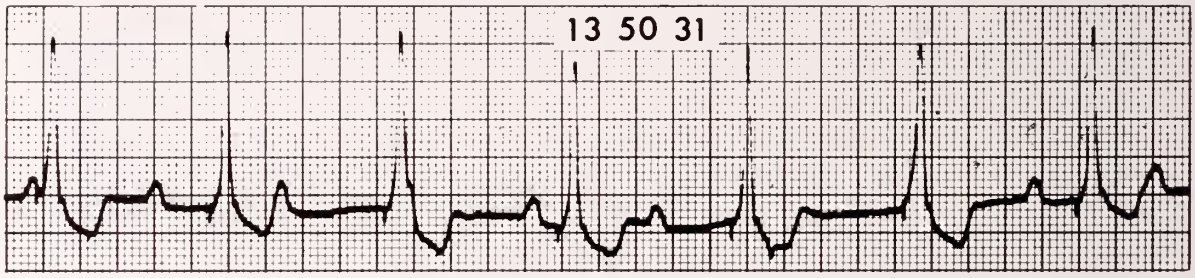


Figure 14
Regular response to pacemaker at 64/min.; sinus rate 88/min.

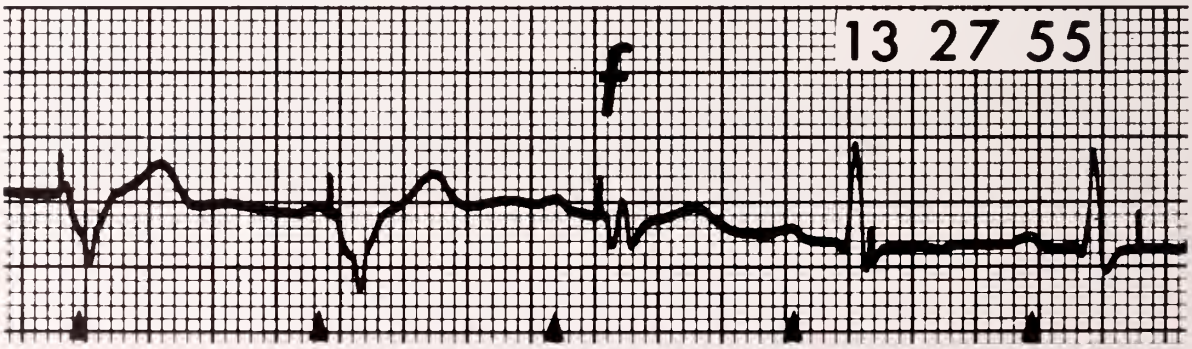


Figure 15
Pacemaker competition.

first two QRS complexes are broad and bizarre, and are caused by the artificial pacemaker. The fourth and fifth occur in response to P waves (PR interval 0.21 second). Because of the difference in rates, they are closely followed by the input from the artificial device which elicits no response. The third QRS complex is clearly a fusion beat; the W-shaped complex results from the algebraic summation of the broad negative component and of the narrow positive component that precisely bisects it.

Summary

This paper is concerned with the electrocardiographic features of heart block, a condition in which interest recently has increased owing to spectacular advances in therapy. Examples of the different degrees of heart block are shown, including the Wenckebach and Mobitz variants of second degree block. The occurrence of cycle-to-cycle fluctuations in the degree of block in some patients is illustrated. Retrograde conduction of impulses to the atria occasionally is seen even in the presence of complete (orthograde) AV block, both before and after insertion of pacemaking devices. The different electrophysiological phenomena underlying Stokes-Adams attacks are discussed and examples of some of them shown. Instances of (1) complete capture of the ventricles and (2) competition between the restored normal conduction mechanism and the artificial pacemaker for control of ventricles (iatrogenic parasystole) also are shown. Many other electrocardiographic phenomena may occur subsequent to pacemaking. They are, however, beyond the scope of the present paper but will be reported subsequently.

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A Key Site of Action of the Protoveratrine A in Salutensin

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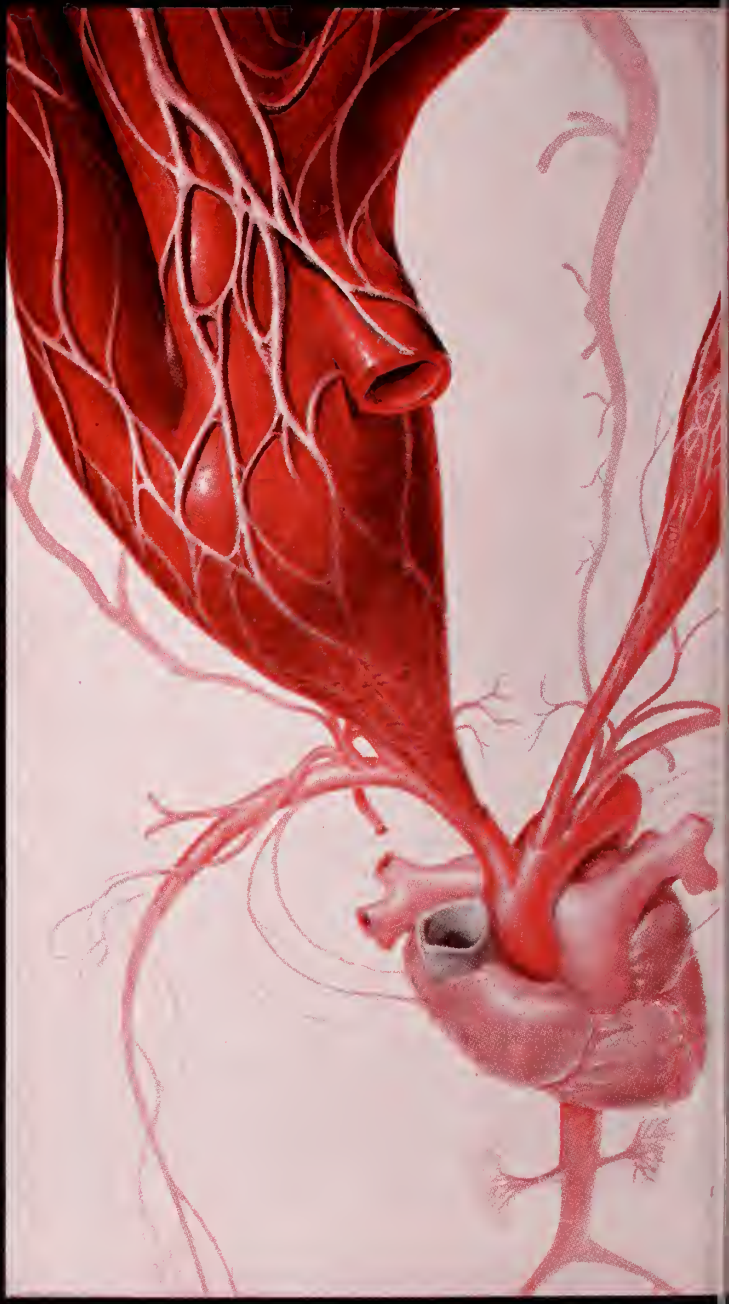

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References: 1. Editorial: JAMA *191*:592 (Feb. 15) 1965. 2. Meilman, E., in Moyer, J.H.: Hypertension, Philadelphia, W. B. Saunders Company, 1959, p. 395.

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Side Effects: Hydroflumethiazide: Purpura plus or minus thrombocytopenia, hyperuricemia, leukopenia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)
Usual Dose: 1 tablet *b.i.d.*

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Cardiac Manifestations of Collagen Disorders*

Daniel Hamaty, M. D.

Cardiac involvement in collagen diseases may cause the presenting complaint or contribute a great deal to the clinical manifestations of the disease. The latter is frequent as the disease devolutes.

This review is presented to reinforce these facts, alerting the clinician caring for cardiac and collagen diseases to early recognition and perhaps reversing the process with such measures as adrenal corticosteroid therapy. Recent reports of systemic lupus induced by specific cardiac drugs also motivates us to a reexamination of this problem.[1, 2]

Certain common pathologic and clinical features of this group of diseases have caused their consideration as such in medical practice. Whether one calls them collagen, auto-immune, mesenchymal, or by another name, is still only a matter of communication rather than an etiologic implication. Nevertheless, evidence is strongly in favor of delayed hypersensitivity playing at least a mechanistic role in these conditions.[3, 4, 5, 6] Induced and spontaneous animal and human experimental models lead even the most skeptical to this inductive reasoning.[7] Hypersensitivity may play a role in other cardiac diseases.[8, 9]

Frequency

Upon reviewing the literature, certain frequency generalizations become evident. Of the classical collagen disorders (variants and other additions to this group seen limitless) systemic lupus erythematosus (SLE) causes heart disease most frequently, followed by scleroderma or progressive systemic sclerosis (PSS) and polyarteritis nodosa (PAN). Adequate figures are not available for dermatomyositis.

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Table 1 presents a composite average per cent incidence of necropsy findings in case reports of the classic collagen diseases plus ankylosing-spondylitis (AS) and rheumatoid arthritis (RA). Correlating this pathology clinically: Coronary arteritis may cause presenting signs and symptoms in PAN; it is infrequent in the others. Pericarditis may herald the onset of PAN, SLE and PSS; it usually is clinically insignificant in RA. Myocarditis may be the presenting and fatal mechanism in RA and AS. Endocarditis is frequent in SLE clinically and pathologically but usually an incidental finding in RA, at necropsy. Some type of pathology is found in all cases of SLE that are posted and in the majority of PAN, PSS and RA. In those cases of AS examined. heart lesions are found in approximately 30 per cent. (See individual disease discussions for references.)

Table 2 presents compiled average incidence figures of clinically identifiable cardiac disorders occurring at some time during the disease. It will be noted that only two of the five, PAN and SLE, exceed the average population prevalence of hypertension; also, considering the average age

Table 1

INCIDENCE OF POST MORTEM CARDIAC PATHOLOGY IN THE MAJOR COLLAGEN DISEASES

(all figures average per cent)

Disease	*Coronary Arteritis*	*Pericarditis*	*Myocarditis*	*Endocarditis*	*All Pathology*
Polyarteritis nodosa	62*	33**	less than 5	less than 5	64
Systemic lupus erythematosus	less than 5	70**	65	40*	100
Progressive systemic sclerosis	less than 5	less than 5**	75**	12	70
Rheumatoid arthritis	18	44	29**	68	85
Ankylosing spondylitis	less than 5	10	20*	....	30

*—often clinically evident.
**—may be a presenting cause. See text for references.

of the victim, SLE deaths due to heart failure are outstanding.

Table 3 presents a frequency average of abnormal ECGs in patients with these conditions. The majority of abnormal tracings are due to myocardial alterations that often are extracardiac in cause. Nevertheless, in PAN, SLE, and PSS, abnormal ECGs are the rule. For comparison, the incidence of clinical arrhythmia is presented. Serious arrhythmias occur in all these conditions. Regardless of incidence, this problem often requires prompt attention. To anticipate them is to the advantage of earlier diagnosis and effective treatment.

Polyarteritis Nodosa (PAN) and Variants

Hypertension, probably secondary to renal arteritis, is the outstanding cardiovascular feature of PAN. An elevated blood pressure is found in approximately 60 per cent of cases.[10, 11] Coronary vasculitis, usually of the smaller branches, coupled with ventricular hypertrophy results in myocardial infarction in 50 to 60 per cent of cases.[10, 11, 12] The infarctions, being multiple and small, seldom are diagnosed ante mortem. Non-uremic pericarditis is found, at necropsy, in 33 per cent, but a friction rub is heard only 9 per cent of the time. Conversely, murmurs are heard in 37 per cent, but endocarditis and myocarditis are found in 2 to 3 per cent only. The cause of death in PAN is shared equally by renal and cardiac failure. Arrhythmias are seldom a problem (10 per cent) although 70 to 85 per cent of cases have been found to have ECG abnormalities.[11]

Various types of arterial inflammatory disease have been suggested as polyarteritis variants (Table 4).[13, 14] These variants do not affect the heart to the extent of PAN. Confusion and disagreement exist in this large group. ("Groupers" and "Splitters"). A few observations are without much dissension, however. Differing from the other collagen-vascular disorders, males predominate over females two to one; there is a closer pathologic relation to drug induced or experimental hypersensitivity; and the kidneys invariably are involved.

The protean clinical spectrum of the arteritides includes constitutional symptoms, occlusive phenomena, hemorrhagic diathesis, tumoral growth, renal failure, hypertension and neurological signs and symptoms. The pathologic findings include endothelial proliferation, arterial wall infiltration with plasma cells and eosinophiles, necrosis, and granulomatous growth of the vascular and privascular tissue.[13, 14, 15, 16]

Takayasu's arteritis or aortic arch syndrome is worthy of special mention since some cases can be aided by surgery. This disease includes features of systemic lupus; it affects young women and may be accompanied by fever, splenomegaly, polymyositis, temporal arteritis, and positive LE cell preparation. Occlusion of the subclavian, carotid and coronary ostia may occur. The disease may be remarkably localized and a "cure" accomplished by graft or by-pass vascular surgery. Careful examination for bruits and pulselessness often is rewarding.[17, 18]

Systemic Lupus Erythematosus (SLE)

The heart seldom is spared in SLE, and, occasionally, isolated pericarditis or hypertension

Table 2

Incidence of Clinical Manifestation of Cardiac Involvement in Collagen Diseases

(all figures average per cent)

Disease	Hypertension	Pericarditis	Endo-myocarditis	Myocardial Infarction	Arrhythmia	Fatal Heart Failure
PAN	60	10	3	55	10	50
SLE	35	30	6	..	2	33
PSS	6	3	6	17	25	..
RA	8	..	..	14	..	20
AS	..	..	5	..	12	..

See text for references.

Table 3

Incidence of Abnormal Electrocardiograms in Patients with Collagen Diseases

(all figures average per cent)

Disease	Abnormal ECG	Clinical Arrhythmia
Polyarteritis nodosa	80	10
Systemic lupus erythematosus	50	2
Progressive systemic sclerosis	75	25
Rheumatoid arthritis	10	less than 2
Ankylosing spondylitis	10	4

See text for references.

Table 4

Possible Variants of Polyarteritis Nodosa

"SPLITTERS"

Hypersensitivity angiitis	Allergic granulomatous angiitis
Temporal arteritis	Wegener's granulomatosis
Midline granuloma	Behcet's disease
Pseudotumor of orbit	Rheumatoid arteritis
Corticosteroid arteritis	Cranial arteritis
Aortic arch syndrome	Arteritis after coarctation resection
Arteritis of hypertension	Buerger's disease
Cryoglobulinemia	Thrombotic thrombocytopenic purpura
Nonspecific localized arteritis	Infectious arteritis

"GROUPERS"

Polyarteritis nodosa
Hypersensitivity angiitis
Wegener's granulomatosis

See text for references.

may be the presenting clinical finding. Later, as is often the case in the collagen diseases, signs and symptoms due to primary cardiac involvement are admixed confusedly with anemic murmurs, asthenia, electrolyte and acid base disturbances, pulmonary involvement and preexisting heart disease. Further perplexing is the poor correlation of murmurs with the presence of Libman-Sacks endocarditis.[19, 20] One series reports a 6 per cent incidence of endocarditis based on careful analysis of frequently heard murmurs which occurred 33 per cent of the time.[21]

Analysis of series of cases reveals a high incidence of renal hypertension (20 to 50 per cent), pericarditis (17 to 45 per cent) with constrictive pericarditis reported, and ECG abnormalities (40 to 60 per cent). Clinical evidence of heart disease is present in approximately 60 per cent of cases.[10, 19, 20, 21, 22] Pericardial tamponade and serious arrhythmias are seldom a problem, but isolated cases have manifested severe heart blocks.[23] Death usually is due to uremia and infection or myocardial failure.

Patchy or diffuse pericarditis is noted at necropsy in 70 per cent of cases, but only 20 per cent are not uremic at the time of death; 14 to 60 per cent show endocarditis, and 50 to 82 per cent show myocarditis.[14, 20]

Adrenal corticosteroid therapy often effectively reverses the cardiac lesions of SLE.

Cases presumably similar to hydralazine (Apresoline) lupus have been reported caused by procaine amide (Pronestyl) and diphenylhydantoin (Dilantin) as well as other drugs. There is some doubt that this type of lupus is reversible when the drug is stopped.[1, 2]

Progressive Systemic Sclerosis (PSS)

PSS, SLE, and PAN similarly affect the heart both directly and indirectly through renal involvement. PSS poses an additional threat to the heart by virtue of pulmonary disease. The direct cause of death is usually renal failure or *cor pulmonale*.[24] As the myocardium is involved by hypertrophy and fibrosis, serious arrhythmias may be found in up to 50 per cent of cases.[24, 25, 26] At necropsy, endocarditis with nodules and pericarditis are infrequent, and patchy acute vasculitis is not seen, although murmurs are heard frequently,[24, 27, 28] but myocarditis is frequently found.[29] Pericarditis of a constrictive and calcifying variety has been reported.[30] Steinberg,[31] et al, submit that pericarditis with effusion is more frequent than suspected.

Adrenal corticosteroid therapy has been futile in PSS, although probably not harmful as once was thought, even in cases with renal involvement. Other drugs have been advocated but none is effective in halting the devolution of the lesions.

Dermatomyositis

In one series of 19 cases of dermatomyositis, clinically evident cardiac involvement was found in eight. Myocarditis and coronary vasculitis seldom are severe enough in dermatomyositis to produce signs or symptoms. Large series of cases are not available. Three cases showed only electrocardiographic or minimal clinical findings, two showed cardiomegaly alone, and three showed marked functional impairment. One necropsy revealed myocarditis and mural endocarditis, another showed myocarditis and micro-endocarditis. As in PSS, severe arrhythmias are seen occasionally, but congestive failure is uncommon.[10, 32]

Pearson[33] has pointed out the desirability of differentiating polymyositis from dermatomyositis in spite of the so-called typical dermatomyositic lesions in the former. Other collagen diseases occasionally showing considerable myositis (e.g., progressive systemic sclerosis, systemic lupus erythematosus and Sjogren's snydrome) are considered apart from classic dermatomyositis.[34] Demonstrations of allergy to tumor cells[35] and to an extrinsic allergen strongly suggest an immunologic basis for dermatomyositis.[36]

Adrenal corticosteroid therapy often is beneficial in this condition.

Rheumatoid Arthritis and Variants

Until the standard diagnostic criteria were established for rheumatoid arthritis,[37] it was impossible to assess the frequency and nature of cardiac involvement; formerly, other rheumatic conditions, rheumatic fever or allergic states were labelled as rheumatoid arthritis. Juvenile rheumatoid arthritis and ankylosing spondylitis are now considered as separate entities. The incidence of systolic murmurs, hypertension, coronary heart disease, and *cor pulmonale* is 20 per cent greater in rheumatoid arthritis than in a control population of patients with other chronic diseases.[38] Cardiac lesions may result in premature death in at least 22 per cent of cases.[39] This figure may be as high as 50 per cent when the clinical course of the disease is progressive and accompanied by pericarditis, heart block, amyloidosis or acute vasculitis.[40, 41, 42]

There is a striking disproportion between the clinical and pathological incidence of cardiac disease in rheumatoid arthritis. An 85 per cent incidence of lesions is reported in autopsy series.[38, 39, 43] Valvulitis, pericarditis, myocard-

itis, rheumatoid nodules, aortitis, coronary angiitis and atherosclerosis were found, in that order. The electrocardiogram is not abnormal at statistical levels of significance.[38] This finding may be explained by the mild and diffuse nature of the lesions found in most cases.

A peculiar aortitis occurs in 1 to 10 per cent of cases of ankylosing spondylitis, depending upon the duration of the disease. These patients are almost invariably men with severe disease, iritis, and peripheral joint involvement. The course of the disease is insidious and progressive, much as in rheumatic fever. Heart failure, angina pectoris, and pericarditis are frequent and may antedate the murmur. Many have had the disease for 15 years or longer before aortitis is noted. Pathologic findings are similar to those of syphilitic aortitis with vasculities of the vasa vasorum, fibrosis and dilatation of the aorta with valvular incompetence; the aortic cusps do not fuse. The inflammatory process may extend into the septum with resulting heart block in 8 to 15 per cent of cases. Cardiac manifestations of the type seen in rheumatoid arthritis seldom are encountered either clinically or at post mortem.[44, 45, 46, 47, 48, 49]

Juvenile rheumatoid arthritis (Still's disease) shows features in common both with adult rheumatoid arthritis and ankylosing spondylitis.[51] It shares the cardiovascular involvement of both in 10 to 17 per cent of cases.[52] A common clinical problem is the differentiation between juvenile rheumatoid disease with carditis and rheumatic fever.[52, 53]

Of the remaining rheumatoid variants, psoriatic arthritis, the arthritis of ulcerative colitis and Reiter's syndrome, only the last has been reported to have concurrent cardiac disease. Symptoms and signs included pericardial friction rubs, aortic and mitral murmurs.[54, 55, 56]

Summary

When viewed from the aspect of cardiology, the literature review of primarily five diseases that usually are considered collagen diseases (namely, polyarteritis nodosa, systemic lupus erythematosus, progressive systemic sclerosis, rheumatoid arthritis, and ankylosing spondylitis) has revealed the following generalizations:

1. Cardiac involvement is frequent and, at times, the cause of death; such involvement may be the only sign of the disease on superficial study, or it may be insidious.
2. The involvement may be reversed by early diagnosis and treatment, to include adrenal corticosteroids.
3. Certain drugs, including cardiac drugs, may cause collagen disease.
4. The involvement is more frequent at post mortem than suspected clinically.
5. Arrhythmias are a particular hazard in these diseases.
6. Other cardiac manifestations isolated or present insidiously are: pericarditis of any type, hypertension, heart failure, myocardial infarction and confusing murmurs.

A list of references may be obtained by writing to The Journal.

Drug Dilemma for Medicare Patients

I share the view of many that the (hospital) pharmacy and therapeutics committee, even when it operates most effectively, offers an incomplete and illusory method of providing the Medicare patient's drugs. The range of drugs available to the patient may vary with the hospital. The patient who leaves the hospital and enters a nursing home may find that his drug supply is no longer paid for.

I confess confusion as to why these patients are not permitted to have the same drugs the rest of us use, in light of this country's extremely rigid drug law and a $54,000,000 FDA budget to enforce it.—C. Joseph Stetler, in *Texas State Journal of Medicine.*

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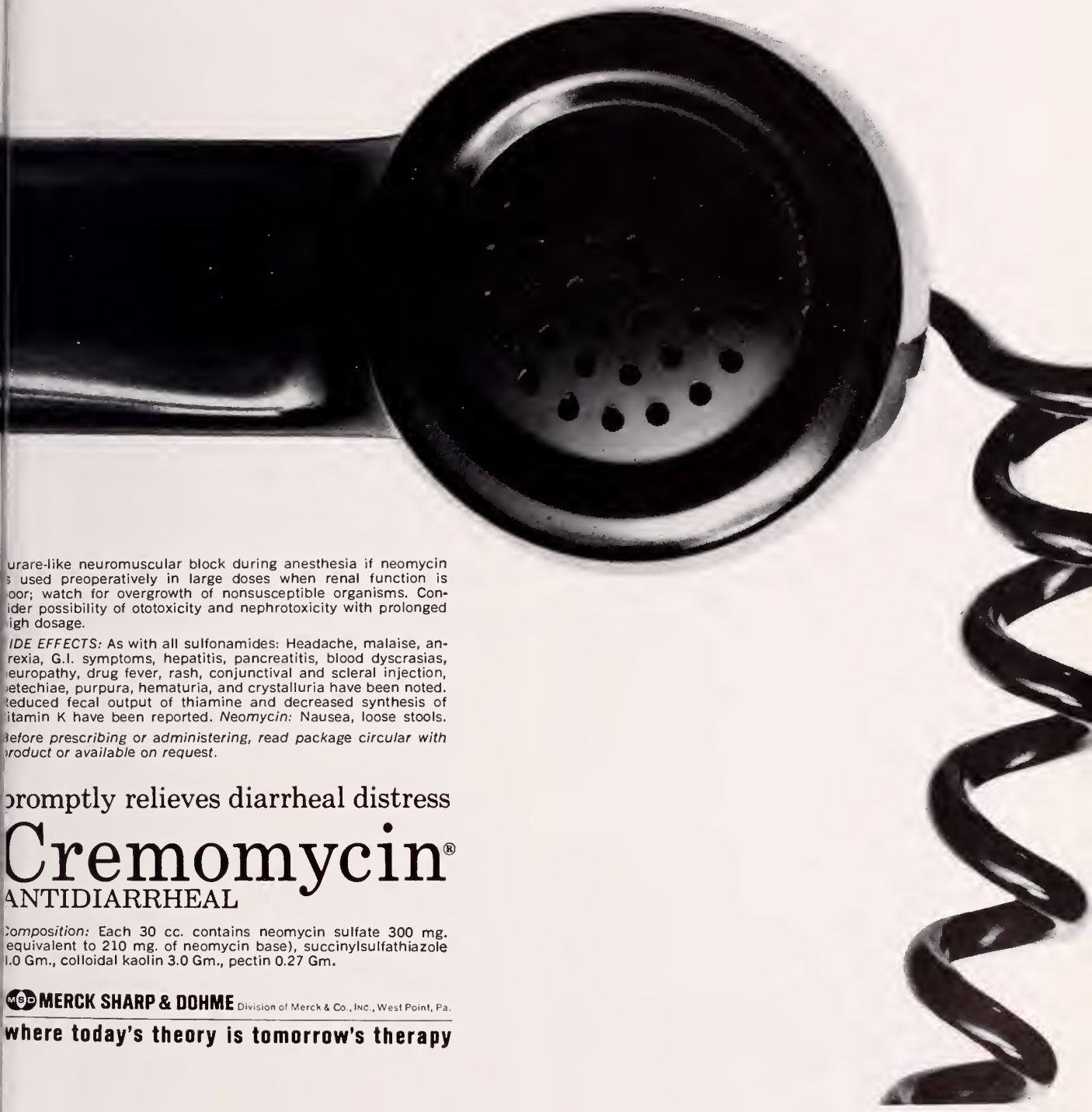

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Current Views on Lipids and Pathogenesis Of Coronary Artery Disease*†

Margaret J. Albrink, M. D.

"WHAT a hope it is to hold . . . to an unfailing bodily health, a constant vigor and tranquility of mind, to preserve these into a green and rugged old age until, without a struggle or a sickness, body and soul part company." Kalau von Boerhaave, 1737.

It is toward just such a hope that current concern with vascular disease is directed. The present paper represents the views of the author on the causes and consequences of abnormal lipid metabolism in its relation to the pathogenesis of atherosclerotic vascular disease.

Pathogenesis

The atherosclerotic plaque consists of a subendothelial collection of cholesterol, phospholipids and triglycerides. Local factors such as injury or hemodynamic stress may determine the site and frequency of plaque formation but the lipids, at least the cholesterol and triglycerides, evidently are derived from the circulation. While some entry of lipid into the arterial wall is normal, when the entry of lipid becomes too great or the metabolic processes by which it is removed are too slow, lipid accumulation becomes excessive and plaque formation results.

The early plaque consists largely of triglycerides. Cholesterol is not prominent. With time the triglycerides are metabolized, leaving behind the nonmetabolizable cholesterol. While cholesterol is the inciting agent of the atherosclerotic plaque, the triglycerides have much to do with the physical state of cholesterol and hence its entry into the subendothelial spaces.

Plasma Lipids

All the plasma lipids are transported as lipoproteins. Increased concentration of the lipoproteins is associated with increased incidence of coronary artery disease. The lipoproteins may be classified by electrophoresis or by centrifugation into several classes of varying density. These are reflected in the cholesterol and triglyceride concentration of whole serum. An increase in cholesterol alone, pure hypercholesterolemia, sugnifies an increase in the smaller beta lipoprotein molecules. The serum is clear. An increase in this class of lipoproteins is associated with increased incidence of atherosclerosis. An increase only in the triglycerides, on the other hand, causes a cloudy serum and signifies that the cholesterol is present in giant very low density lipoproteins which are particularly atherogenic and which carry the cholesterol into the subendothelial spaces. An increase in triglyceride concentration, even though the total cholesterol is normal, also is associated with increased atherosclerosis.

Basis for Assessment

It is not necessary to remember the various classes of lipoproteins and the difficult terminology for denoting them. Knowledge of the cholesterol and triglyceride concentrations is enough to permit assessment of the lipid aspects of the atherogenic tendency of any individual.

Since we first reported the association between serum triglyceride concentration and coronary artery disease in 1956, amplified in later papers,[1] several studies have confirmed this relationship. They are almost evenly divided on the question of whether triglyceride or cholesterol is the better indicator of risk of coronary disease. The answer obviously is that both are of significance. Furthermore, since cholesterol and triglycerides are associated variables, the independent evaluation of each is difficult. This very association, however, provides a clue that a disturbance in triglyceride metabolism may in many instances cause an increase in cholesterol as a secondary phenomenon. In any event, an understanding of the metabolic causes of elevated triglyceride concentration (hyperglyceridemia) is essential to the

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problem of prevention and treatment of atherosclerosis.

The interrelation of plasma cholesterol and coronary artery disease was shown by Paul[2] et al in a long-term study of normal factory workers. With increase in cholesterol concentration from 205 to 256 mg. per cent, the four-year incidence of coronary artery disease increased from 1.6 per cent to 4 per cent. A study, however, of the prevalence of hyperglyceridemia (triglycerides over 5.4 mEq./L or 150 mg. per 100 ml.) derived from a different but similar factory population showed that as the cholesterol increased from 200 to 260 mg. per cent the triglycerides also increased.[1] Seventy to eighty per cent of the men with cholesterol over 260 mg. per cent also had high triglycerides. The increased incidence of coronary artery disease could then also have been due to the triglycerides rather than to the cholesterol.

Brown[3] and co-workers, in Albany, measured both cholesterol and triglycerides in a long-term study. They showed that both components were important. For any given concentration of cholesterol, coronary disease increased with rise in triglyceride concentration. Similarly, for any given triglyceride concentration, coronary artery disease increased in increase in cholesterol concentration. An exception was an increase of cholesterol over 260 mg. per cent which carried equal risk for coronary artery disease whether or not the triglycerides were increased.

The important influence of triglyceride then is in the middle range of cholesterol concentration between 200 and 260 mg. per cent. Nearly half the normal population falls in this group and the majority of new cases of coronary artery disease.

The causes of increased cholesterol and of increased triglycerides are then both germane to the problem of atherosclerosis, its prevention and treatment.

Cholesterol.—The National Diet Heart Study is based on the premise that increased serum cholesterol is due to an increased intake of animal fat in diet and that it can be reduced by a moderate reduction of dietary fat and an increase in the amount of unsaturated vegetable fat. A new or rediscovered factor is the importance of dietary cholesterol *per se*. For an intake between 0 and 700 mg./day, the dietary cholesterol does have a small but significant influence on serum cholesterol concentration. This suggests the advisability of eliminating from the diet the concentrated sources of cholesterol such as egg yoke, organ meat, shell fish, butter and butter fat. Meat has a moderate cholesterol concentration but if meat is the only source of cholesterol, the dietary cholesterol will not be excessive.

Even with elimination of dietary cholesterol and with institution of the low-saturated fat high-unsaturated fat diet, only small changes in the cholesterol concentration are to be expected. A search for other correctable metabolic lesions is thus all the more important.

Triglycerides.—An investigation of the causes of hypertriglyceridemia has revealed a relation not with dietary fat, as was the case with plasma cholesterol, but with abnormal carbohydrate metabolism. Impaired carbohydrate metabolism of mild but definite degree as well as hypertriglyceridemia is common in patients with coronary artery disease. Elevated serum triglycerides, and impaired glucose tolerance and increased vascular disease are associated in diabetes.

Carbohydrate Tolerance

These various associations raised the question of whether increased triglycerides in normal people or in patients with coronary artery disease could be either the cause or the result of impaired carbohydrate metabolism. Studies of carbohydrate metabolism in patients with a wide range of plasma triglyceride concentrations showed a distinct though low grade correlation between fasting blood sugar and triglyceride concentration even within the normal range for blood sugar. A much closer association was found between elevated plasma triglycerides and impaired glucose tolerance determined both by oral and intravenous glucose tolerance tests.[4]

Plasma Insulin.—Recent investigations in the field of diabetes have shown that patients with mild or early diabetes, rather than suffering a deficiency of insulin, actually respond to a carbohydrate meal with an excessive rise in circulating insulin. That is, the higher than normal rise in blood sugar is associated with an increased insulin response. The paradox of mild diabetes in the face of excessive circulating insulin is indicative of some metabolic resistance to the action of the insulin, that is, insulin resistance.

Since patients with high concentrations of plasma triglycerides frequently have mild diabetes, they, too, might be expected to show both insulin resistance and excess circulating insulin. As expected, patients with elevated plasma triglycerides responded to an intravenous dose of exogenous insulin with much less lowering of the blood sugar than persons with normal triglycerides. Persons with elevated serum plasma

cholesterol concentrations responded in a similar fashion. Thus, insulin resistance is an important feature both of hypertriglyceridemia and hypercholesterolemia.[5]

Dr. Paul Davidson in our department has set up an immunochemical method for the assay of endogenous insulin, thus making it possible to test the hypothesis that patients with hypertriglyceridemia respond to a carbohydrate meal with excessive secretion of endogenous insulin. He found, indeed, that there was a correlation between the concentration of circulating triglycerides and the magnitude of insulin rise following a carbohydrate meal. Since excessive insulin response has been reported both in obese patients and mild diabetics, however, and since elevated plasma triglycerides are common in both conditions, it was important to rule out the possibility that the excessive insulin response was due merely to mild diabetes or obesity. When only patients who were neither obese nor diabetic (2 hours p. c. glucose over 120 mg. per cent was taken to indicate diabetes) were tested, there was still a marked difference in insulin response between those persons with normal triglycerides and those with elevated triglycerides. For example, one hour after the ingestion of 100 Gm. of glucose, the mean plasma insulin of persons with normal triglycerides was 81 micro units per milliliter, while that of patients with elevated triglycerides (over 5.5 mEq./L or 150 mg. per cent) was 199 micro units per milliliter ($p < 0.001$).[6]

Metabolic Characteristics of Patients With Vascular Disease

Because of the known association between plasma triglycerides and vascular disease on the one hand, and between plasma triglycerides and various abnormalities of carbohydrate metabolism on the other, the possibility is raised that similar abberations might be found in patients with vascular disease whether or not the lipids are abnormal. Consequently, for the complete investigation of patients who have or are suspected of having vascular disease we measure not only the plasma cholesterol and triglyceride concentrations but look also for impaired glucose tolerance, insulin resistance, and excess insulin response to a carbohydrate meal. Almost all patients with atherosclerosis are found to have one or another, if not several, of these defects. Patients with excessive insulin response already may have marked vascular disease even though the plasma lipids and the glucose tolerance are entirely normal.

A reasonable guess now can be hazarded as to the sequence of events in the development of the above cluster of metabolic phenomena. First comes either excessive insulin response, possibly due to dietary factors such as ingestion of too much purified carbohydrate, or, alternatively, first might come resistance to the action of insulin. The latter could be an inherited trait present only in patients with genetic diabetes. In either event a vicious cycle becomes established in which excessive insulin response may cause hypoglycemia and thus provoke the body's defenses against hypoglycemia, such as increased secretion of growth hormone, of cortisol or of epinephrine. The resultant insulin resistance would place increased demand on the pancreas for yet more insulin. So long as the pancreas can produce sufficient insulin to overcome the insulin resistance, carbohydrate tolerance will be normal but as the pancreas begins to fail mild diabetes makes its appearance.

The increase in the circulating plasma lipids, particularly the triglycerides is probably part of the mechanism of insulin resistance stimulated in turn by the excessive insulin response. A possible direct deleterious effect of the excess insulin on arteries also must be considered.

Treatment of Vascular Disease

The lowering of plasma cholesterol by moderate restriction of dietary fat and substitution of polyunsaturated for saturated fats has been well established although the possible benefits to be gained from this procedure are not yet known. The increase, however, in dietary carbohydrate necessitated by restriction of dietary fat in order to keep total calories constant would on theoretical grounds be just the wrong treatment for patients in whom the cluster of metabolic abnormalities associated with hypertriglyceridemia are present. As outlined above, patients with hypertriglyceridemia respond to carbohydrate feeding by excessive insulin response, insulin resistance and impaired glucose tolerance. If the excess insulin response is rather basic in the etiology of this cluster of events and since the excessive insulin response occurs following carbohydrate feeding, the logical treatment of patients with one or more of these abnormalities would be not to restrict dietary fat but to restrict dietary carbohydrate.

Such treatment is quite in keeping with the new knowledge concerning carbohydrate-induced lipemia. Recent work has shown that there are two main types of hyperlipemia (cloudy serum, elevation of plasma triglycerides): fat induced and carbohydrate induced. The latter is by far the more common and is the more likely to be associated with mild diabetes and with

premature atherosclerotic vascular disease. While fat induced lipemia is made worse by increased dietary fat, carbohydrate induced lipemia actually is improved by low carbohydrate, high fat diets.

Until the response to various diets has been more carefully worked out, our plan is to assess patients with vascular disease first by carrying out a rather complete battery of tests including glucose tolerance tests with measurement of circulating insulin, as well as of plasma lipids, then to assess the influence of various diets on these parameters. Only on such empirical grounds can we be sure that we have recommended the correct diet for each individual patient.

Perhaps the single most important aspect of dietary treatment is that of weight reduction in overweight patients. Loss of weight usually is accompanied by reversal of all the metabolic abnormalities to or toward normal, regardless of the diet employed for the weight reduction.

Summary

The role of plasma cholesterol and triglycerides in the pathogenesis of atherosclerosis is reviewed.

While hypercholesterolemia may be caused by excessive ingestion of animal fat and of cholesterol, hypertriglyceridemia is more closely related to a cluster of abnormalities of carbohydrate metabolism. These include mildly impaired glucose tolerance, excessive rise in plasma insulin concentration following a carbohydrate meal, and insulin resistance. Weight loss or carbohydrate restriction may correct these pathological responses.

For proper assessment of any dietary regimen, not only the plasma lipids but carbohydrate tolerance and insulin response must be measured.

Insulin resistance may be the basic metabolic lesion of atherosclerosis.

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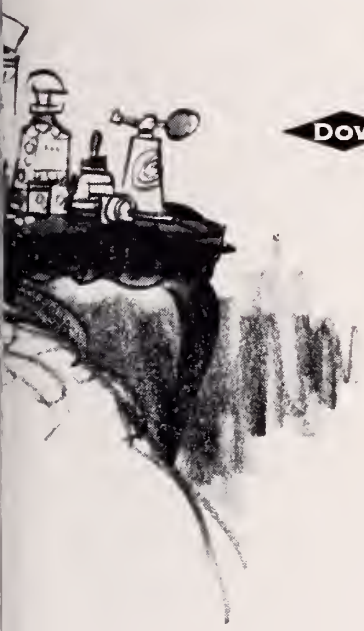

Management of Foreign Bodies of The Tracheobronchial Tree in Children

Philip M. Sprinkle, M. D.

Most all practicing physicians have had training to a certain extent in the endoscopic management of foreign bodies of the tracheobronchial tree. Almost every one of them could be called upon at any time to contribute their aid in making the diagnosis and in selecting the proper treatment in such cases. Accordingly, current thought regarding the problems encountered in arriving at the proper diagnosis and treatment in these instances is presented.

It actually is unnecessary to review here the usual clinical findings associated with foreign bodies of the tracheobronchial tree since excellent reviews already are available.[1, 2, 3] I shall, therefore, confine my remarks and comments to those problems very frequently associated with the management of these cases.

Problems in Diagnosis

The diagnosis of a foreign body of the tracheobronchial tree can be painfully obvious with marked respiratory distress or obvious radiopacity on chest x-ray. The diagnosis of foreign bodies in children, however, all too often is missed. Chevalier Jackson[1] reported that in his large series of cases, more than 13 per cent had been overlooked by the physician for periods ranging from one month to many years.

The small child with some inability to communicate may not be able to give a coherent history of having put a colored bead in his mouth and inhaled it. Children, having been admonished by their parents against their carelessness, actually may fear relating to them the history having strangled on an object that had been placed in the mouth.

In fact, patients with foreign material in the air passage, particularly if the foreign substance is well tolerated by the body, may experience a symptomless interval lasting several days, weeks or months. During the period in which the patient is symptom free, the incident of coughing secondary to the primary aspiration may well have been forgotten.

Unfortunately, failure to remember the presence of a foreign body in one's tracheobronchial tree is not limited to the patient. Simple failure on the part of the physician to consider the possibility of a foreign body has resulted in much needless suffering and useless therapy.

Submitted to the Publication Committee, March 10, 1966.

The Author

- **Philip M. Sprinkle, M. D., Chairman, Division of Otolaryngology, West Virginia University School of Medicine, Morgantown.**

Foreign bodies frequently simulate other pulmonary disease conditions such as asthma, bronchitis, atelectasis, bronchiectasis and empyema. Lobar pneumonia probably is the rarest complication. These factors necessitate inclusion of tracheobronchial foreign body in the differential diagnosis of various pulmonary disorders and necessitating thereby, the routine use of diagnostic aids including x-ray, fluoroscopy, laminography and, whenever the diagnosis is in doubt, endoscopic evaluation. All of these features point to the principle of teamwork; team effort by the pediatrician, the radiologist, the anesthesiologist and the endoscopist being a prerequisite in cases of unexplained lower respiratory disease in children.

Problems of Pediatric Endoscopy

Bronchoscopy in children differs in its greatest aspect in that the larynx of the infant or child is less tolerant of instrumentation than that of the adult. The loose areolar submucosal tissue of the subglottic larynx swells promptly on exposure to minor trauma. The degree of subglottic reaction depends upon the amount of laryngeal inflammation already present, the size of the bronchoscope used, and the amount of trauma produced by the endoscopist.

Problems of Anesthesia

The question of whether or not to use general anesthesia can be real enough. Resolution of this problem is not complete, but there are several salient features on which to base final judgment applicable to the individual case.

In cases in which there are large, usually tracheal, foreign bodies and in which death

appears imminent and almost any type of anesthesia would be hazardous, my recommendation would be no anesthesia. May I suggest, however, that at the time of a true emergency bronchoscopy, an anesthesiologist should be standing by. His day-to-day familiarity with airway problems renders the anesthesiologist an invaluable and time-saving asset.

For the bronchial foreign bodies, there seems to be good reason for the use of general anesthesia in selected cases. The decision to use or not to use general anesthesia, however, should be reached jointly by the endoscopist and the anesthesiologist. I most certainly agree with the work of Baker[4] who reported on a series of cases of foreign body in each of which removal was accomplished with the patient under general anesthesia. Baker[4] reported also on a group of patients, in each of which removal was carried out, with the use of no anesthesia.

This study[4] seems to confirm the impression that there is no essential difference in the ultimate result, all other factors being equal. When considering the case of the struggling child, with its attempts to phonate against the bronchoscope, the suggestion that general anesthesia could serve to decrease trauma to the vocal cords and subglottic area seems real enough. There is, in my opinion, a merited place for general anesthesia in the endoscopist's armamentarium. The suggestion also can be made that the more inexperienced endoscopist or perhaps the endoscopist-in-training could derive greater benefit from the use of a general anesthetic when applicable.

When indicated, the general anesthesia of choice from my own experience would be nonflammable methoxyflurane (Penthrane) anesthesia, preferably used with muscular relaxants. Methoxyflurane, being a first cousin of ether, has the latter's advantages without its explosion hazard. It has the additional advantage that with it, the topical vasoconstrictor adrenalin may be used without a resultant predisposition to cardiac arrhythmias.

The local tissue reaction to foreign bodies can be quite marked. The reaction is more severe in children, as a rule, then in adults. The lowly peanut probably produces the most edema. Simple topical application of adrenalin through the bronchoscope will give maximal shrinkage of any edematous area surrounding a foreign body, rendering the latter more easily accessible, thus easier to remove.

Problems With Endoscopy

Preoperative preparation of all equipment is a necessity. Extra light carriers must be present and functional. An assortment of infants' and children's bronchoscopes is absolutely necessary. It is true that the larger the scope, the more operating room for the endoscopist; but it is equally true that an excessively large bronchoscope can cause additional trauma.

All foreign body forceps should be sterilized since the type of the foreign body in any given case cannot always be determined. The surgeon, therefore, should be prepared for as many types of foreign body as possible.

Use of Corticosteroids

At this point, let me comment on the use of corticosteroids. In the pediatric age group, trauma to the vocal cords can and does result in the necessity for tracheotomy. The work of Dolowitz and Daughtery[5] points out that inflammation is a nonspecific reaction to trauma. The work of these two observers, further supported by results of the investigations of Tausk[6] and Spurr,[7] shows that the corticosteroids are more effective in prevention of inflammation and, in particular, of the edema of inflammation, than they are when used in the treatment and reduction of edema after the latter is produced.

It has become my practice, therefore, to use a single intravenous dose of 100 mg. cortisone or its equivalent prior to the endoscopic procedure. This, it seems, is of greater value than that noted in its use after the trauma to the vocal cords has been delivered. It is true that frequently corticosteroids will be given when the trauma to the vocal cords was small, but this opinion can only be concluded postoperatively when efficacy of the corticosteroids would be of lesser degree. In addition, a single intravenous dose, as suggested, would be expected to produce no untoward reactions, neither would it complicate anesthesia nor the preoperative or postoperative care.

Actual Performance of Bronchoscopy

As to performing the actual bronchoscopy, one interesting note is the introduction of the bronchoscope. Bronchoscopy, with less trauma to the cords usually can be accomplished by introduction of the bronchoscope through a pediatric laryngoscope. The laryngoscope, an infant or child Jackson scope with removable back, makes possible removal of the laryngoscope from around the bronchoscope.

A quick check of the uninvolved side of the lung should be made first. While bilateral for-

eign body does occur, such occurrences fortunately are rare. Check of the uninvolved area first will obviate the necessity of re-introducing the bronchoscope subsequent to removal of the foreign body. As has already been noted, if endobronchial edema is present about the foreign body, more operating space can be obtained by inserting adrenalin, in small amounts and of proper concentration, through the bronchoscope.

Finally, may I comment on the matter of postoperative care? Humidity and careful observation should, of course, be used. Strict avoidance of any sedation is the rule to be obeyed in all instances.

If the bronchoscopy was a lengthy or traumatic procedure, continued use of the corticosteroids for at least a 24-hour period must be considered.

Only a brief comment upon prophylaxis. In Jackson's[1] large series of cases of foreign body of the tracheobronchial tree in children, carelessness always was the primary predisposing factor. Each and every parent should be cautioned regarding the practice of leaving small objects within reach of infants and children. Dietary habits should be stressed in order that infants and children be not given peanuts and similar foods to eat. These instructions might well become routine or considered as routine in the well-baby clinic.

Again, in Jackson's series of cases, another unusual feature, interestingly enough, was poverty. Ninety-one and nine-tenths per cent (91.9%) of all cases of foreign body of the tracheobronchial tree in children either were wholly charity or part charity cases. This, as of this writing, still is an unlegislated segment of the poverty program, cases that undoubtedly will require a physician's care and thought for some time to come.

Summary

Problems encountered in the management of tracheobronchial foreign body in children are discussed. Attention is directed to problems in diagnosis, problems in pediatric endoscopy, problems with anesthesia and those met at the time of actual endoscopy including preoperative and postoperative care.

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The Importance of Drug Advertising

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Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculapapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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A message from . . .

The President

LEST WE/I FORGET

WHO of us is brave enough to turn the other cheek? "To err is human; to forgive, divine." All of us at sometime or another has had occasion to do something for someone—not for a return "something," although many will interpret the act as such.

Be that as it may, someone will always "not like" or "be against" something. Why? Most dislikes are based on inadequate knowledge of the subject or person and for every dislike, a little more understanding makes it a like.

Let that suffice as an introduction to a plea for tolerance. I'm planning on making more friends than enemies, but I know *everyone* not *always* will be pleased, and that with the rush of this and that (plus trying to make a living) I'll probably forget to thank someone for a job well done or for a kindness that a million thanks couldn't repay. I think each month I'll say "thank you" as a general statement to try to make up for those careless but not planned omissions.

The Committees have been chosen with care and I know someone who has been missed will want on one. It would be a pleasure to know of these instances, because these men will make good Committeemen.

Committee meetings have skyrocketed in recent years and especially in recent months. These meetings are important and, as in the past, I know the affairs of State this year will go on because of these active Committees.

Likewise, the Centennial plans are being made and any ideas will be appreciated and soon, please; a year is a short time, you know.

Although some concrete plans have been formulated, it seems fitting to write here of the Centennial Medallion which was thought of by me and developed by Mr. Mitchell Sagan, a real artist, of Weirton. This Medallion is a work of art, a real beauty! Aside from the satisfaction he had in doing it, I'm sure that will be the sum total of his pay.

Thanks to all of you who will make this a nice year—the State Office force: Bill, Ed, Mary and Judy, my fellow doctors, committeemen, patients, and especially my family which will bear the brunt of any rough road ahead.

I'm not just being cranky—just acting out that old adage: "You always hurt the one you love."

Richard E. Flood, M. D., President

THE WEST VIRGINIA MEDICAL JOURNAL

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EDITORIALS

A REPORT TO THE MEMBERSHIP

There was an obvious feeling of tension hovering over the 115th Annual Meeting of the American Medical Association which was held in Chicago in June. In looking back over the many years and the many battles to hold down legislation which would probably move towards socialization of medicine, it finally dawned upon the majority of us there that the day following this meeting this country would embark upon a great program in which medical services would be offered to its citizens regardless of their ability to pay. Although Medicare was discussed quite frequently, there appeared to be many thoughts of doubts for the future in the minds of the Delegates and other representatives of medicine who were gathered for the meeting.

On Sunday prior to the opening of the meeting, the State Presidents Meeting was honored by the appearance of Mr. Richard Nixon, who made an excellent impression on those present. Although the larger part of his talk was about Vietnam, he again raised doubt as to the wisdom of offering the great amount of free medical services to the people of our country that is promised under Medicare legislation. It is interesting to note that Mr. Nixon makes an excellent impression personally, but we could not help but note that same evening when he appeared on television that he was at a disadvantage before the television cameras. It is difficult to explain why.

Medicare, physician's billing procedures, medical ethics, racial discrimination, health manpower and an increase in the annual AMA dues were among the issues acted upon during the meeting. Approximately 120 resolutions were offered, all of which dealt with some phase of the previously mentioned subjects.

It should be pointed out that although they disagreed with the Medicare law, our officers of the AMA felt that it was an obligation to obey a law of the land, if one is a responsible citizen, and that every effort should be made to provide expert assistance so that the law could be implemented in the manner most helpful to their patients, and at the same time not disturb the practice of medicine any more than absolutely necessary.

The House again reaffirmed the principle that the matter of billing under PL 89-97 was entirely an individual responsibility. It was suggested that direct billing for the present would minimize the confusion which is bound to occur. In addition the House urged positive steps to obtain statutory authority for a continuing medical advisory committee under Title 19, and it called on the AMA and the state societies to maintain added vigilance to eliminate any patterns which might subvert the intent of Title 19.

The House again took steps to protect the great number of hospital-based physicians throughout the nation in declaring that it was unethical for a physician to displace a hospital-based physician who is attempting to practice separate billing when said displacement is primarily designed to circumvent separate billing.

There were six resolutions dealing with the subject of discrimination against some applicants for membership in component medical societies. In lieu of the six resolutions, the House adopted a substitute resolution which directed the Council on Constitution and By-laws to prepare such changes "as may be necessary to permit the Judicial Council to receive and act upon appeals filed by applicants who allege that they have been unfairly denied membership in a local and/or state society." The House asked the Council to report its recommendation at the 1966 Clinical Convention.

On the subject of manpower, the House noted that the necessary additional manpower in the medical profession and in allied health professions must be developed. The House approved the Board of Trustees' report announcing the appointment of a Committee on Health Manpower and adopted the resolution.

The AMA dues increase of $25 per year was opposed vigorously by the states of New York, New Jersey and others. Pursuant to instructions given during the January meeting of the Council of the West Virginia State Medical Association, your delegates voted against the increase in dues; however, the dues increase was authorized by a vote of 168-46. Since the New York delegation has 26 votes, it appears obvious that the great majority of states were for the increase.

The definition of usual, customary and reasonable fees was referred back to the Council on Medical Services for study, and the House also reaffirmed its opposition to the compulsory regulation of any single method, such as the use of generic terms, of the prescribing of drugs.

The House instructed the appointment of a Claim Review Insurance Committee, which will also be at the disposal of the Board of Trustees in negotiating any new contract for the disability program.

The House also approved the reapportionment of delegate representatives. A resolution introduced by the West Virginia delegation was studied by the Board of Trustees. The House approved the suggestion that if and when the House reached a numerical value of 250, the various states would be represented by one delegate to each 1,250 physicians, and no state would lose its present numerical representation.

Dr. Milford O. Rouse of Dallas, Texas, was elected President Elect without opposition. Dr. Walter C. Bornemeier of Chicago was elected Speaker of the House of Delegates and Dr. Eli S. Jones of Hammond, Indiana, Vice President, both without opposition. The race for Vice Speaker of the House was fought bitterly and Dr. Russell B. Roth of Erie, Pennsylvania, was victor over John H. Budd of Ohio. These two men were excellent candidates and well qualified for the office, and it appeared to most of us that Doctor Budd's entrance into the race was too late to be successful.

On the Board of Trustees, all for three year terms, Dr. Homer L. Pearson of Miami and Dr. D. L. Wilbur of San Francisco were re-elected; Dr. Burtis E. Montgomery of Harrisburg, Illinois, was named to succeed Dr. Percy E. Hopkins of Chicago, who did not run for re-election; and Dr. Max H. Parrott of Portland, Oregon, succeeded Dr. Raymond M. McKeown, who was not eligible for re-election.

For the Council on Medical Education, Dr. Kenneth C. Sawyer of Denver, Colorado, was re-elected and Dr. James W. Haviland of Seattle, Washington, succeeded Dr. Melvin W. Breese of Portland, Oregon, who did not wish renomination.

For the Council on Medical Service, the House re-elected Dr. Charles E. Ashworth of Providence, Rhode Island; named Dr. Guy A. Owsley of Hartford City, Indiana, to succeed Doctor Montgomery; and elected Dr. John R. Kernodle of Burlington, North Carolina, to replace Doctor Roth. Dr. James M. Kolb, Sr., of Clarksville, Arkansas, was re-elected to the Council on Constitution and By-laws. Named to the Judicial Council were Dr. Renato Azzari of New York City to succeed Dr. Robertson Ward of San Rafael, California; and Dr. George W. Petznick of Cleveland, Ohio, to succeed the late Dr. J. H. Berge of Seattle, Washington.

It is obvious with the great number of resolutions presented that many other subjects were discussed and many deliberations were gone into in great depth; however, it appears to your Delegates that this type of informal report should bring out some of the interesting points.

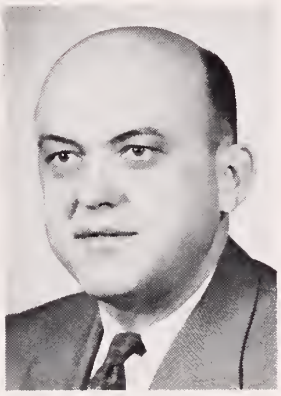
F. J. Holroyd, M. D.
C. A. Hoffman, M. D.
Delegates.

GENERAL NEWS

19th Annual Rural Health Conference At Jackson's Mill on Oct. 6

Dr. Bond L. Bible of Chicago, Secretary of the Council on Rural Health of the American Medical Association, will be the keynote speaker at the 19th Annual Rural Health Conference which will be held at Jackson's Mill on Thursday, October 6. The theme for the one-day Conference is "Expanding Horizons in Comprehensive Rural Health Care."

Norman H. Davis



Bond Bible, Ph. D.

Doctor Bible, a native of Centre County, Pennsylvania, received B.S., M.S. and Ph.D. degrees from Pennsylvania State University. From 1937 to 1956, he taught vocational agriculture at various schools in West Virginia and Pennsylvania.

His keynote address will be based around the theme "Toward Excellence in Country Living" with major emphasis on community health planning for the emerging rural community structure.

More than 250 persons are expected to attend the Conference which is sponsored annually by the West Virginia State Medical Association in cooperation with the West Virginia Home Demonstration Council, the State Department of Health, the West Virginia Farm Bureau, and the Cooperative Extension Service of West Virginia University.

Dr. Martha Jane Coyner of Harrisville, who is in charge of this year's Conference, will call the meeting to order in the Assembly Hall promptly at 10 A.M. The invocation will be given by Dr. Stanley H. Martin, President of West Virginia Wesleyan College.

Another speaker at the morning session will be Mr. Norman H. Davis of Chicago, Director of the Medical Programs for The Sears-Roebuck Foundation. His subject will be "The Community Medical Self-Help Plan."

The third speaker at the morning session will be Dr. Robert R. Huntley, Assistant Professor of Preventive Medicine and Medicine at the University of North Carolina School of Medicine. He also serves on a part-time basis as co-director of the staff of the Health Advisory Committee of the Appalachian Regional Commission.

Doctor Huntley's subject will be "The Comprehensive Concept of Community Health Services."

Luncheon will be served in the Mt. Vernon Dining Hall at 12:15 P.M. with the West Virginia State Medical Association as host.

Panel Discussion on 'Medicare'

Dr. Richard E. Flood of Weirton, President of the State Medical Association, will deliver the address of welcome at the opening of the afternoon session.

The afternoon session will be devoted to a panel discussion on the Medicare program which went into effect on July 1. Each of the participants will speak briefly and most of the afternoon session will be devoted to a question and answer period with active audience participation.

Dr. N. H. Dyer, State Director of Health, will serve as moderator and the other participants will be as follows:

Dr. B. B. Richmond, Medical Director of the Health Insurance Benefits Unit, State Health Department.

Mr. Harry Parker, Director of Administration for the State Health Department's Health Insurance Benefits Unit.

N. H. Dyer, M. D.

R. R. Huntley, M. D.

Mr. Robert Campbell, Medicare Manager for Nationwide Mutual Insurance Company in West Virginia.

Mr. Dudley Rumbaugh, Director of Hospital and Professional Relations, Blue Cross-Blue Shield Plans of Charleston.

Mrs. Oleta Riffe, Director of the Bureau of Public Health Nursing of the State Department of Health.

Dr. Seigle W. Parks, Immediate Past President of the State Medical Association.

Mr. Marco M. Rudd of Clarksburg, Assistant District Manager of the Social Security Administration.

The Conference is open to members of all interested groups and an invitation to attend the meeting is being extended to members of local farm bureaus, home demonstration councils, agricultural extension workers and personnel of local health departments.

Advisory Committee

The program for the Conference was planned by members of the Advisory Committee to the State Medical Association's Rural Health Committee.

In addition to Doctor Coyner, the other members are Mrs. J. B. McCue of Summersville, President of the West Virginia Home Demonstration Council; Miss Gertrude Humphreys of Morgantown, former State Extension Home Demonstration Leader; Miss Virginia R. Griffin of Morgantown, State Chairman, Extension Education Programs for Women; Dr. N. H. Dyer, State Director of Health; Mrs. Hu C. Myers of Philippi, President of the Woman's Auxiliary to the State Medical Association; Mrs. Lynwood D. Zinn of Clarksburg, Chairman of the Auxiliary's Rural Health Committee; and Mr. E. O. Gregory of Buckhannon, Secretary of the West Virginia Farm Bureau.

Diabetes Treatment Symposium In Huntington

The Cabell County Medical Society will sponsor a Symposium on "Recent Advances in the Treatment of Diabetes" at the Hotel Frederick in Huntington on October 15.

Speakers will include: Dr. Edwin G. Beven of the Department of Vascular Surgery, Cleveland Clinic, Cleveland; Dr. John G. Floyd of the University of Michigan Medical School in Ann Arbor; Dr. George W. Hamwi, Professor of Medicine at Ohio State University School of Medicine, Columbus; and Dr. Leo Krall of the Joslin Clinic in Boston, Massachusetts.

Further information may be obtained by writing to Dr. David A. Haught, Suite 707, First Huntington National Bank Building, Huntington, West Virginia 25701.

New Society Is Formed

The Society for Cryo-Ophthalmology has been organized to promote investigative and clinical applications of low-temperature technics to the eye.

Membership applications will be accepted from those interested in the investigative aspects of this subject, the preservation of ocular tissue, therapeutic applications of cryogenics to various ocular diseases, and cryosurgical technics.

Inquiries and applications should be addressed to Dr. John G. Bellows, 30 North Michigan Boulevard, Chicago, Illinois 60601.

Convention Story Will Appear In October Journal

The 99th Annual Meeting of the West Virginia State Medical Association was being held at The Greenbrier in White Sulphur Springs as this issue of *The Journal* went to press.

The full convention story, including information concerning new officers of both the State Medical Association and Auxiliary, as well as heads of sections and affiliated societies and associations, will be carried in the October issue.

Four State Physicians Named ACCP Fellows

Four West Virginia physicians were admitted as Fellows of the American College of Chest Physicians during the 32nd Annual Meeting of the ACCP in Chicago, June 24-27.

The West Virginians are Drs. Willard Pushkin and Harold Selinger, both of Charleston, John B. Harley of Morgantown and Hilton Rocha of Hopemont.

The ACCP installed new officers as follows:

Dr. Howell S. Randolph of Phoenix, Arizona, President; Dr. William A. Adams of Chicago, President Elect; Dr. Coleman B. Rabin of New York City, First Vice President; Dr. Arthur M. Olsen of Rochester, Minnesota, Second Vice President.

Dr. Albert A. Andrews of Chicago, Treasurer; Dr. Karl Pfeutze of Hinsdale, Illinois, Assistant Treasurer; Dr. Howard Van Orstrand of Cleveland, Chairman of the Board of Regents; and Dr. Otto Brantigan of Baltimore, Chairman of the Board of Governors.

The College registered 1,748 physicians and others at the Annual Meeting.

Interstate PG Program In Washington

The 1966 Assembly of the Interstate Postgraduate Medical Association will be held at the Sheraton-Park Hotel in Washington, October 17-20.

Interstate is not a membership organization. Its sole function is to present an annual scientific assembly which is open to any M. D. in the United States or Canada.

Dr. Walter H. Judd of Washington, former Congressman and Medical Missionary, will speak at the Annual Dinner on October 19. His topic will be: "Where in the World Are We Going?"

The program is acceptable for 18 accredited hours by the American Academy of General Practice.

Additional information may be obtained by writing to Dr. Alton Ochsner, Program Chairman, Interstate Postgraduate Medical Association, Box 1109, Madison, Wisconsin 53701.

New Association Members

Dr. James C. Branch, Cabell-Huntington Hospital, Huntington (Cabell). Doctor Branch, a native of Logan, was graduated from UCLA and received his M. D. degree in 1959 from Johns Hopkins University School of Medicine. He interned at Johns Hopkins University Hospital and served a residency at Yale University Hospital, 1961-65. He served with the United States Air Force, 1950-52, and was licensed to practice in West Virginia in 1965. His specialty is pathology.

* * * *

Dr. Jaldir Lobo, 708 1st Huntington National Bank Building, Huntington (Cabell). Doctor Lobo, who was born in Brazil, was educated in that country and received his M. D. degree in 1952. He interned at St. Mary's Hospital in Huntington, 1953-54, and served residencies at St. Mary's, the Medical College of Virginia Hospitals and the University of Louisville Hospitals. He was licensed to practice medicine in West Virginia in 1966 and his specialty is neurosurgery.

* * * *

Dr. Frank E. Medford, Union Carbide Corporation, South Charleston (Kanawha). Doctor Medford, a native of Asheville, North Carolina, was graduated from Wake Forest College and received his M. D. degree in 1961 from the Bowman Gray School of Medicine. He interned at Charleston Memorial Hospital, 1961-62, and served a residency at the same hospital, 1962-65. He was licensed to practice medicine in West Virginia in 1966 and his specialty is internal medicine.

* * * *

Dr. Arthur L. Poffenbarger, 501 Atlas Building, Charleston (Kanawha). Doctor Poffenbarger, a native of Charleston, was graduated from Virginia Military Institute and received his M. D. degree in 1959 from the University of Maryland School of Medicine. He interned at Charleston Memorial Hospital, 1959-60, and served a residency at University Hospital in Baltimore, 1960-63. He served as a Captain in the Medical Corps of the United States Army, 1963-65. His specialty is neurology.

* * * *

Dr. James T. Woelfel, 422 Tenth Street, Huntington (Cabell). Doctor Woelfel, a native of Huntington, was graduated from Marshall University and received his M. D. degree in 1959 from Marquette University School of Medicine. He interned at Milwaukee County Hospital, 1959-60, and served a residency at St. Joseph's Hospital in Milwaukee, 1960-63. He served as a Captain in the Medical Corps of the United States Army and his specialty is surgery.

PG Course in Cardiology

The Division of Continuation Medical Education of the University of Kentucky College of Medicine will conduct a postgraduate course in "Cardiac Emergencies" in Lexington, September 9-10.

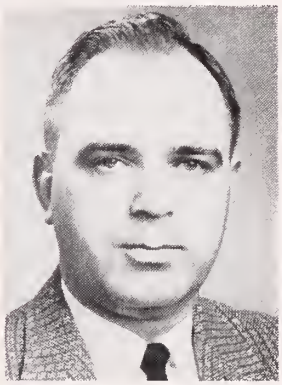
The registration fee is $30. Additional information may be obtained by writing to Director of Continuation Medical Education, College of Medicine, University of Kentucky College of Medicine, Lexington, Kentucky 40506.

State Heart Group Plans Scientific Meeting

The West Virginia Heart Association will conduct its scientific sessions at the West Virginia University Medical Center in Morgantown, September 23-24.

A Symposium on Strokes will be held on Friday, September 23. Saturday's scientific program will consist of a Symposium on Pulmonary Hypertension.

Byron M. Bloor, M. D.



A. C. Edmundowicz, M. D.

The speakers who will present papers on Friday and their topics are as follows:

James D. Martin, M. D., Department of Neurology, WVU. Subject: "Physiology and Pathology of Strokes."

Byron M. Bloor, M. D., and Robert G. Nugent, M. D., Division of Neurosurgery, WVU. Subjects: "Clinical and Radiological Evaluation of Strokes" and "Vascular Reactivity and Results of Surgical Treatment of Strokes."

Hartwell G. Thompson, Jr., M. D., Department of Neurology, WVU. Subject: "Medical Management and Rehabilitation."

The speakers at the Saturday session and their topics are as follows:

Alphonse C. Edmundowicz, M. D., Department of Medicine, WVU. Subject: "Physiology of the Pulmonary Circulation."

Russell V. Lucas, Jr., M. D., Department of Pediatrics, University of Minnesota. Subject: "Pulmonary Hypertension in Congenital Heart Disease."

Yang Wang, M. D., Department of Medicine, University of Minnesota. Subject: "Pulmonary Hypertension in Acquired Heart Disease."

Herbert E. Warden, M. D., Department of Surgery, WVU. Subject: "Surgical Aspects of Pulmonary Hypertension."

Other highlights of the meeting will include the General Assembly on September 23. The keynote address will be presented by Doctor Lucas. A "Charge to Panels" will be presented by Dr. Albert D. Kistin of Beckley, President of the Association, and the group will divide into six panels: "Balanced Year-Round Programing"; "Impact of Federal Legislation on the Heart Association"; "Cardiopulmonary Resuscitation"; "Memorials and Bequests"; "A New Look at Heart Policy"; and "Volunteer Achievement."

All physicians are invited to attend the sessions. Reservations may be made by writing to the West Virginia Heart Association, 759 West Washington Street, Charleston, West Virginia 25302.

Heart, Cancer and Stroke Services Discussed

A planning project to improve heart, cancer, and stroke services in five southern counties was the subject of a recent issue of the "State of the State's Health" by State Health Director N. H. Dyer. Doctor Dyer noted that the program could have considerable impact upon the state's major health problems.

The project proposes to develop comprehensive community planning and service activities that will result in: (1) the expansion of existing health services in the area, (2) the coordination of the health services in terms of these being more efficient and more effective, (3) the development of new services and facilities not now available in the area, and (4) the increase in the utilization of these services.

Doctor Dyer mentioned that of the 16 states receiving Community Health Planning Grants, West Virginia ranked third highest in amount awarded—$59,767. He said funding for the project began July 1, 1966, and will continue through June 30, 1969.

"Initially, this project will concern itself with activities in the Mercer County area that will result in the more effective delivery of improved services to patients in the entire five-county area," Doctor Dyer said. "These planning and service activities will be concerned with the organization, coordination, and delivery of comprehensive services of heart, cancer, and stroke patients containing the essential components of preventive measures, casefinding, diagnosis, management, health education and counselling, referral, rehabilitation, and follow-up."

"Heart disease, cancer, and stroke are the three leading causes of death in West Virginia," Doctor Dyer pointed out. "And, the five-county area has the greatest morbidity and premature mortality in the state. In fact, overall mortality rates for heart disease are higher in this area than nationally. The highest prevalence of rheumatic fever and rheumatic heart disease in the state is in this area. The project area death rate for 'other diseases of the heart' doubled while that for the state remained constant. Hypertension mortality is consistently higher in the area than statewide. And, there is a higher ratio of cancer cases classified as unknown in this area."

Doctor Dyer noted factors pertinent to the problem—the non-white population segment represents 13 per cent of the total population, a relative shift in population age group favors an increase in the high-risk groups over 65, and per capita income is lower and the percentage of families with income under $3,000 is higher than national and state averages.

He said all of these factors relate directly to the need for expansion of community health services and pointed up a larger segment of the population at risk as well as a larger segment that is unable to provide these services for themselves. "Preventing the mortality and removing the burden of providing adequate services to patients unable to pay for medical care has long been the number one health problem in the state," he said.

"Especially disturbing have been survey results which show many high poverty level areas where certain health resources are maintained at a high ratio and yet, paradoxically, these resources are having no effect upon the service needs of heart, cancer, and stroke patients in indigent groups; nor are these resources having any impact upon the prevalence and incidence rates for these three disease categories in those population segments most susceptible to them-the medically indigent and the aged," Doctor Dyer added.

"Perhaps, sufficient facilities and manpower, in certain areas, are present but not efficient as they might be in meeting the terms of total community health need. A lack of coordination and planning is evident," Doctor Dyer observed. "There is also a need for the collection and analysis of service statistics in every community to further identify the high risk groups so that appropriate educative and preventive measures may be directed to these particular groups."

Doctor Dyer said that this project provides an opportunity to plan, evaluate, and develop a coordinated effort in the Mercer regional area to expand services to heart, cancer, and stroke patients. "The services of existing private and public agencies will be utilized as resource to provide as effective a preventive and out-of-the-hospital service program to heart, cancer, and stroke patients as possible."

"Project activity will be carefully recorded, the involvement and contribution of each community or private agency will be documented, and the entire effort evaluated from phase to phase so that this coordinated approach in the Mercer region to this old problem may serve as a prototype for increasing and improving services to heart, cancer, and stroke patients in communities all over the state," Doctor Dyer concluded.

Psychiatry for the GP

A seminar on various practical aspects of neurology and psychiatry for the general practitioner will be conducted at the Homestead in Hot Springs, Virginia, January 26-28.

The program will be sponsored by the Department of Neurology and Psychiatry of the University of Virginia School of Medicine.

Additional information may be obtained by writing to the Director of Continuing Education, Dean's Office, University of Virginia School of Medicine, Charlottesville, Virginia.

ACP Schedules PG Course

The American College of Physicians will conduct a postgraduate course in "The Care of the Critically Ill Medical Patient" in Syracuse, New York, October 3-7.

Registration fees are $60 for members of the ACP and $100 for nonmembers.

Requests for additional information should be addressed to Dr. Edward C. Rosenow, Jr., Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

'Measurement of Depression' Film Available

A drug manufacturer is making available a film entitled "The Measurement of Depression," which depicts the development, validation and use of a scale for the quantitative measurement of depression.

The scale was designed by Dr. William W. K. Zung, a psychiatrist in Durham, North Carolina. Although initially devised for use in psychiatric research, the scale lends itself to the general practice of medicine, where most depressions are first encountered.

The 22-minute, 16 mm. sound and color film is designed for medical educational purposes at meetings of hospital staffs, county societies or specialty groups. The self-rating scales, available in quantity for use in office practice, come complete with full instructions.

Both the film and scale pads are available free upon request from Lakeside Laboratories, Inc., Medical Film Department, 1707 East North Avenue, Milwaukee, Wisconsin 53201.

TB Association Schedules Annual Meeting

The 46th Annual Meeting of the West Virginia Tuberculosis and Health Association will be held on September 7 at the Daniel Boone Hotel in Charleston.

Sen. Jennings Randolph will be the luncheon speaker, while Dr. Joseph B. Stocklen of Cleveland will be the speaker at the banquet that evening.

The West Virginia Thoracic Society will conduct its annual business meeting at 11 A.M. on September 7. The West Virginia Conference of Tuberculosis Workers will have its annual business dinner at 6:30 P.M. on Tuesday, September 6.

Mortality Changes Little, Study Shows

Mortality among persons insured in 18 large life insurance companies has changed very little during the past decade, according to the new annual report of the Society of Actuaries' Committee on Mortality.

The report reviewed the 1963-64 experience under ordinary insurance policies issued at standard rates, and in lesser detail, experience over the past 25 years.

The 1963-64 mortality on policies in force less than 16 years was slightly higher than the experience of the preceding year, but slightly lower on policies in force longer than 15 years.

For standard insurance issued without a medical examination, mortality continued higher than on medically issued business. The difference increases with age; the excess mortality is more than 10 per cent at issue ages above 30. The mortality on non-medical policies remains higher even after 15 or more years have elapsed.

New AMA President Elect Is Native Texan

Dr. Milford O. Rouse of Dallas, Texas, who was named President Elect of the American Medical Association in Chicago last June, is a native of Jacksonville, Texas.

He was born in 1902 and because his parents were Baptist missionaries, he spent part of his boyhood in Cuba and Brazil. His desire to become a physician dates back to his early childhood when a Brazilian doctor saved his life.

Milford O. Rouse, M. D.

After receiving an M.A. degree, Doctor Rouse earned his M.D. degree from the Baylor Universty College of Medicine in 1927.

He has practiced in Dallas since 1928, specializing in gastroentrology.

Since 1943, Doctor Rouse has been Clinical Professor of Medicine at the University of Texas Southwestern Medical School, and he previously taught in the Baylor University College of Medicine's Department of Medicine, when that school was located in Dallas.

Doctor Rouse is a Past President of the Dallas Southern Clinical Society, the Texas Society of Gastroenterologists and Proctologists and the Texas Medical Association. He is a member of the Texas Academy of Internal Medicine, the Texas Geriatric Society, the Dallas Academy of Internal Medicine, the American Gastroenterological Association and the American Therapeutic Society.

He is a Diplomate of the American Board of Internal Medicine and the Board of Gastroenterology and a Fellow of the American College of Physicians. He was President of the Southern Medical Association in 1958-59.

Prior to being named AMA President Elect, Doctor Rouse served as Speaker of the AMA House of Delegates for three years and Vice Speaker for four years.

Doctor Rouse was married in 1927 to a Baylor classmate, the former Leaureame McDavid of Henderson, Texas. They have one daughter, Mrs. C. L. Sawyer of Dallas, and three grandchildren.

Gastroenterology Course

The American College of Gastroenterology will present its annual course in postgraduate gastroenterology at the Bellevue Stratford Hotel in Philadelphia, October 27-29.

Subject matter will include the diagnosis and treatment of gastrointestinal diseases and comprehensive discussions of diseases of the esophagus, stomach, pancreas, liver, gallbladder, small intestine and colon.

Additional information may be obtained by writing to the American College of Gastroenterology, 33 West 60th Street, New York, New York 10023.

Easter Seal Society Slates Meeting

Some of the nation's outstanding authorities on the rehabilitation of the handicapped will gather in Pittsburgh, November 10-13, for the annual convention of the National Society for Crippled Children and Adults.

They will include: Miss Mary E. Switzer, Commissioner of the U. S. Vocational Rehabilitation Administration; Dr. Howard A. Rusk, Director of the Institute of Physical Medicine and Rehabilitation, New York University Medical Center; and Dr. Eli Ginzberg, Director of Conservation of Human Resources, Columbia University.

Special sessions will be held during the convention on two areas of growing concern in the rehabilitation field: the critical shortage of physical, occupational and speech therapists, nurses, technicians and other rehabilitation professionals; and the large number of children who suffer from minimal brain dysfunction.

The program will include a luncheon for Jimmy Durante, 1966 Easter Seal Chairman. He will receive a special award for his service to crippled children.

Additional information may be obtained by writing to the National Society for Crippled Children and Adults, 2023 West Ogden Avenue, Chicago, Illinois 60612.

Former Auxiliary President Dies in Huntington

Mrs. Ann Yates Swann, a Past President of the Woman's Auxiliary to the West Virginia State Medical Association, died on July 22 in a Huntington hospital. She was the wife of Dr. Walter C. Swann of Huntington.

A native of Cabell County, Mrs. Swann was a graduate of Marshall University and formerly taught school in Boone County.

Survivors, in addition to Doctor Swann, include: a daughter, Mrs. Willard B. Chellis of Huntington; two granddaughters; a brother, Walter B. Yates of Kenova; and a nephew, Dr. Walter K. Yates of Huntington.

Symposium on Arthritis In Norfolk

An Arthritis Symposium will be conducted at the Lake Wright Motor Hotel in Norfolk, Virginia, October 7-8.

Eight physicians from other states will present papers at the Symposium, which is sponsored by the Tidewater Branch of the Arthritis Foundation and the Norfolk County Medical Society.

Additional information may be obtained by writing to Marcia F. Misel, Executive Secretary, The Arthritis Foundation, Room 306, 809 Brandon Avenue, Norfolk, Virginia 23517.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1966

Sept. 8-10—Am. Assn. of Ob.-Gyn., Hot Springs, Va.
Sept. 9—Maryland Medical, Ocean City.
Sept. 16-24—Am. Soc. of Clinical Path., Washington.
Sept. 17-23—Col. of Am. Pathologists, Chicago.
Sept. 20-22—Kentucky Medical, Louisville.
Sept. 23-24—W. Va. Heart Assn., Morgantown.
Sept. 23-Oct. 1—Am. Soc. of Clinical Pathologists, Chicago.
Sept. 27-28—AMA Cong. on Occupational Health, Portland, Ore.
Sept. 30-Oct. 2—W. Va. Div., Am. Cancer Soc., Cacapon State Park.

Oct. 1-5—Am. Soc. of Anesthesiologists, Philadelphia.
Oct. 6—Rural Health Conf., Jackson's Mill.
Oct. 7-8—AMA Cong. on Medical Quackery, Chicago.
Oct. 10-13—AAGP, Boston.
Oct. 10-14—ACS, San Francisco.
Oct. 11-14—Pennsylvania Medical, Pittsburgh.
Oct. 13-15—Assn. of Am. Phy. & Surg., Disneyland, Calif.
Oct. 15—Cabell County Symposium, Huntington.
Oct. 15-16—Am. Assn. of Oph., Chicago.
Oct. 16-21—Am. Acad. of Oph. & Otol., Chicago.
Oct. 21-25—Am. Heart Assn., New York.
Oct. 22-27—Am. Acad. of Pediatrics, Chicago.
Oct. 23-26—Am. Col. of Gastroenterology, Philadelphia.
Oct. 28-30—Potomac-Shenandoah Valley PG Inst., Martinsburg.
Oct. 31-Nov. 4—Am. Assn. of Public Health Physicians, San Francisco.

Nov. 6-9—Med. Soc. of Virginia, Williamsburg.
Nov. 14-17—Southern Med. Assn., Washington.
Nov. 15-20—Am. Medical Womens Assn., Washington.
Nov. 26-27—Am. Col. of Chest Physicians, Las Vegas.
Nov. 27-30—AMA Clinical Convention, Las Vegas.
Nov. 27—Nat. Conf. on the Med. Aspects of Sports, Las Vegas.
Nov. 29-Dec. 1—Am. Acad. for Cerebral Palsy, Biloxi-Gulfport, Miss.

Dec. 2-3—Am. Rheumatism Assn., Cincinnati.
Dec. 3-6—Am. Acad. for Cerebral Palsy, New Orleans.
Dec. 3-8—Am. Acad. of Dermatology, Bal Harbour, Fla.
Dec. 4-7—Am. Soc. of Hematology, New Orleans.
Dec. 6-8—Southern Surgical Assn., Boca Raton, Fla.

1967

Jan. 14-19—Am. Acad. of Orthopaedic Surgeons, San Francisco.
Jan. 28-Feb. 1—Am. Acad. of Allergy, Phoenix.
Feb. 14-19—Am. Col. of Cardiology, Washington.
March 10-11—AMA Conf. on Rural Health, Charlotte, N. C.
March 9-11—AMA-ABA National Medicolegal Symposium, Miami Beach.
March 19-24—Southeastern Surgical Cong., Bal Harbour, Fla.
April 3-5—Am. Acad. of Ped., San Francisco.
April 7-9—Am. Soc. of Int. Med., San Francisco.
April 10-14—Am. Col. of Physicians, San Francisco.
April 16-20—Am. Col. of Ob. & Gyn., Philadelphia.
April 23-26—W. Va. Acad. of Oph. and Otol., White Sulphur Springs.
April 30-May 2—W. Va. Chapter, AAGP, Huntington.
May 6—Am. Col. of Psychiatrists, Philadelphia.
May 29-June 1—Am. Urol. Assn., New York.

The West Virginia Medical Journal

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President's Report: 1965-1966*

Seigle W. Parks, M. D.

For the past year you have entrusted to me the high honor and responsibility to fill the office of the President of the West Virginia State Medical Association. It is now time to audit the results of my trusteeship and make a report to the membership.

Chapter VI of the By-Laws states in part, that the President's duties include the responsibility of appointing the members of all standing committees—and that he shall act as the real head of the profession of the State—and as far as practicable visit, by appointment, the various sections of the State and assist the councilors in building up the component societies—and shall perform such other duties as custom and parliamentary usage may require.

Under the provisions of the last sentence, although vaguely defined, lie many definite responsibilities, some following the practice of custom and others that require individual decision of the realms of responsibility.

It was my avowed prayer at the outset of my term of office that I would have the wisdom and judgment to interpret your needs and carry out a program that would be in the best interests of our membership and our fellowmen.

In the domain of individual decision of responsibility, it was my considered opinion, that we should concentrate our efforts toward finding the most universally acceptable solutions in those problem areas which most vitally concerned our organization and its members. These problem areas revolved primarily around five subjects: Medicare; emphasis on county medical societies; expanded services of state medical organization; doctor shortage; and paramedical responsibilities.

*Annual Address of the President, West Virginia State Medical Association, 99th Annual Meeting, The Greenbrier, White Sulphur Springs, August 27, 1966.

The Author

- **Seigle W. Parks, M. D., Immediate Past President of the West Virginia State Medical Association.**

Medicare

The year 1966 will go down in history as the year that Medicare was forced upon the public and the medical profession as the greatest social experiment of our times. The medical profession, after 20 years of valiant effort to forestall the socialization of medicine, suffered a telling defeat by the combined effort of the Fabian socialists, union dominated congressmen and the bureaucrats of the L. B. J. administration.

The leaders of medicine after this staggering blow, accepted their responsibility as law abiding citizens and worked courageously to implement this unwanted and unwarranted law, in such a manner as to protect the individual's right of choice of his own physician and the physician's fair practice to receive his usual and customary fee for service by direct billing to his patient. The doctors recognize full well that this is but the first page in the eventual development of further socialization, and place themselves on record that they cannot be held at fault when the failures of this system begin to develop.

We will not be held as the scapegoats when the bureaucrats try to shift the blame for the eventual failures and faults of this socialistic system. The doctors with their principles of ethics will continue to render the highest quality of medical care that this system will allow.

In my original planning, I stressed the necessity of devoting a major portion of my time and

effort in studying the problems of the county medical societies, and working out special projects to facilitate our communications and mutual cooperation. Although the ever demanding problems and numerous meetings of Medicare impeded our progress, it was still possible to visit 20 of the 28 county medical societies, and in most of these visits we were able to conduct a workshop with your officers, in order that I might become more knowledgeable of your problems, and be informed of your desires of how your State Medical Association can best serve you. While extremely beneficial, I feel this is one of the most pleasant responsibilities of being your President.

To renew many old acquaintances and to make many new ones is one of the greatest rewards of medical organizational work. To sit down with doctors from different areas of the State and to discuss your different, yet often similar problems, gives one an expanded and comprehensive viewpoint of our complex nature, which can be understood by few people outside the medical profession.

Reorganization of Councilor Districts

Specifically, several serious problems stood out in our discussions that concerned the county medical society officers, and likewise your President. Perhaps of primary importance was the feeling in some areas that due to their geographical location they were not granted equal representation in our organizational structure. It became apparent that our old method of councilor districts based on the political boundaries of congressional districts is outmoded and does not serve the best interests of many of our physicians and their county medical societies.

Although doctors are conservative by nature, no profession has been quicker to abandon outmoded methods of practice as evidenced by the fact that 90 per cent of our modern therapeutic modalities were unknown a decade ago. With the revolutionary changes challenging organized medicine today we should, after proper evaluation, update our administrative organization in order that we can meet these problems from a position of strength and effectiveness.

This problem of reorganization of our councilor districts has been under discussion for several years, and numerous plans have been recommended and discarded. Now is the time for effective action. Based upon the facts which have been presented to me by officers of the county medical societies, I have charged the Chairman of the Redistricting Committee, Dr. Kenneth G. MacDonald, to present specific recommendations to the 1966 House of Delegates. These recommendations have been approved by his committee and the council.

Of the three new plans presented, the one with the greatest potential and the least objections would divide the State into 14 councilor districts with one councilor instead of two elected for a two-year term and eligible for reelection for another two-year term. The guiding principles in this plan were to provide for equitable representation for all medical areas of our State, to confine the councilor districts to medical service areas where medical liaison, customary consultation and referral, adequate transportation, and medical educational facilities have predetermined them to be areas of most effective influence. The third principle was to strengthen the county medical societies and increase our communication to and from the council and the State Medical Association.

In general this plan recognizes the new concept of regionalization as a means of providing comprehensive medical service to prevent the problems of maldistribution of professional services, and to strengthen those areas with the greatest need and the greatest potential.

The council has recommended that in cases in which the district councilor is a member of another county medical society, he be invited to sit in an advisory capacity to those societies or their executive committees and to report the actions of the council to all societies in his district.

County Medical Society Officers Workshop

For several years my distinguished predecessors have proposed a County Medical Society Officers Workshop to improve our understanding and communications. These plans were brought to a successful culmination in March when we held our first workshop. We were addressed by Dr. Charles L. Hudson, now President of the AMA. His subject was "Closer Cooperation Among County and State Medical Societies and the AMA." He stressed that the individual physician is the very foundation of the AMA and urged greater physician participation in the affairs of organized medicine. Seventeen of the 28 component medical societies sent representatives and the 53 physicians entered into active discussion of the reports presented. Doctor Hudson stressed the necessity of strengthening organized medicine at all levels. He stated, "It is at the local society level that the all important grass root opinions of individual physicians originate." The success of this original meeting indicates the desirability of future workshops.

Expanded Services of the State Medical Association

Article II of our Constitution states: "The purpose of this Association shall be to federate and bring into one compact organization the entire medical profession of the State of West Virginia." As I stated in my President's Page in the September 1965 issue of *The Journal*, "It is my philosophy that the State Medical Association exists to serve the county medical societies." With this in mind, the following steps have been taken to improve our ability to provide additional service:

1. Firm financial status. 2. Modernization of the By-Laws. 3. Active Executive Committee. 4. Strengthen responsibilities of councilors. 5. Increase frequency of Council meetings. 6. Comprehensive postgraduate educational program. 7. Progressive medical economic policy. 8. Cooperative long-range planning. 9. Study and reorganization of councilor districts.

Firm Financial Status

Recognizing that a sound financial operation is essential to the successful administration of any organization, your officers for the past several years have worked to establish a reasonable budget to guide us in the proper expenditure of our available funds. It was apparent that the office of the Treasurer should be given additional responsibilities as the financial overseer and to make periodic reports to the President and the Chairman of the Council.

After lengthy study it became apparent that due to decrease in financial support and gradually increasing cost associated with the requirement for more and more committee meetings, a dues increase was inevitable. After a thorough disclosure of the pressing needs, the House of Delegates last year voted an increase which has placed your organization in a firm financial position. Although operating costs have continued to increase, there is no anticipation that a further dues increase will be necessary for the next few years.

Two positive factors are working in our favor. Due to the excellent work of our Publication Committee, advertising revenues have increased and *The Journal* has resumed its self-supporting position. Secondly, the Council by its own action effected an economy move by voting to forego reimbursement for its travel expenses. It is to the credit of these men and the self-sacrificing members of our many committees that they serve without compensation.

Modernization of By-Laws

Last year the Committee on Constitution and By-Laws under the able leadership of our most knowledgeable Chairman, Dr. James S. Klumpp, completely updated our By-Laws, giving us a modern framework upon which we can build a strong organization. It has been recommended that any county society desiring review of its Constitution and By-Laws may refer them to this Chairman for his recommendations.

Active Executive Committee

Last year the duties and responsibilities of this committee were spelled out and expanded to assist the Council. It is charged with setting up the annual budget with the assistance of the Treasurer and Executive Secretary. Prior to each meeting of the Council, they have met to discuss and prepare the agenda which has expedited the efficient conduct of business of the Council. At the meetings of the AMA, it has sat as an advisory group to our delegates.

Strengthened Responsibilities of Councilors

Feeling that the Councilors are one of the main channels of communication, the Council went on record to recommend that their county medical societies elect them ex-officio members of their Executive Committees. Furthermore, it was recommended that those other county medical societies in each district invite their Councilor to attend their meetings in an advisory capacity. It was further recommended that summaries of the Council's action be furnished to the President of each County Medical Society. These steps will strengthen the responsibilities of the councilor as organizer, advisor, and censor of his district.

Increase Frequency of Council Meetings

Although the By-Laws provide that the Council meet at least four times a year, in the past few years the increased problems and responsibilities have made it necessary to call several special meetings. Since our pre-convention meeting of the Council, August 25, 1965, there have been four additional meetings, with meetings of the Executive Committee the night before each Council session.

Comprehensive Postgraduate Educational Program

Recognizing that one of the primary purposes of our Association is to extend medical knowledge and elevate the standards of medical education, the Committee on Medical Education and Hospitals has directed its efforts toward making a critical analysis of our problems and needs, and to formulate a long-range program that will most adequately fulfill these needs.

Much of the planning is now completed and the Committee's recommendation will be presented in final form. It is in essence a "university without walls" and will be systematically presented to the doctors around the state in medical education workshops. This would encourage and foster a closer cooperation among the medical schools, hospital training centers and the practicing physicians to share mutual educational needs at all levels, including preceptorships, and several satellite training centers in the clinical years.

The Committee resolved that in order to render the highest quality of medical care to the people of West Virginia, we should broaden the medical education of our students as well as our own practicing physicians by establishing supplementary instruction in the clinical years in various areas of our State. Furthermore, recognizing the need for more and better internships and residencies the Committee feels these programs should be developed and upgraded. It was also resolved that we improve and coordinate the postgraduate educational program for our practicing physicians and render more attractive the practice opportunities for new physicians.

In order to organize and develop medical education workshops, the State was divided along lines of medical service areas into eight regions, centered around the teaching or training hospitals at Morgantown (Area 1), Wheeling (Area 2), Martinsburg (Area 3), Parkersburg (Area 4), Charleston (Area 5), Huntington (Area 6), Beckley (Area 7), and Bluefield (Area 8).

Coordinators have been appointed for each area, and they will be responsible for organizing and planning postgraduate educational workshops in their areas under the guidelines established by the Committee on Medical Education.

This hard working Committee deserves our appreciation for its outstanding work.

Progressive Medical Economic Policy

Since the time of the constitutional reorganization of the Medical Economics Committee and its functioning subcommittees, your State Medical Association has been better prepared to protect the welfare of the physicians of our Association. A large measure of this success can be attributed to the Committee's leadership and forthrightness.

In case we are misinterpreted, it is best to state at the outset that the welfare of the patient and his proper medical care have always taken precedence over the personal or economic welfare of the physician. But it is equally important to stress that much of the socio-economic and medical economic problems of West Virginia are related to a common factor. Doctor shortages and maldistribution will improve in direct relationship to the economic welfare of the State and depressed areas. The stronger the economic welfare of the physician the more directly will the patient benefit.

Dr. Albert C. Esposito, in his presidential address last year, recommended that the physicians reject all third party fee schedules and substitute their usual and customary fees for service. The House of Delegates, acting on this recommendation, passed a resolution reaffirming our position against fixed fee schedules and charged the Committee on Medical Economics to negotiate with the various state agencies a system based on "usual and customary charges."

Dr. George R. Callender, Jr., in his "Blueprint for the Future," made this salient observation—"Let us take a lesson from this Medicare legislation and in fact profit from this experience."

Doctor Callender recommended that the Council go on record as approving only third party programs covering an average annual income group which pays the usual and customary charge for service.

Following the intent of these actions, Doctor Callender and Dr. Harry S. Weeks, Chairman of the Conference Committee with the Department of Welfare, have carried out negotiations to establish a system based on usual and customary charges. State Welfare Commissioner L. L. Vincent has been very considerate of our proposal, but a final decision has been deferred pending consideration by Gov. Hulett C. Smith and by the Council.

Negotiations with Brig. Gen. Norman E. Peatfield, Executive Director of the Office for Dependents Medical Care, was concluded by an agreement that we would operate without a contract. It is understood that physicians will make their usual and customary charges, and that a Sub-Committee on Federal Medical Activities will adjudicate the claims in question or refer them to the county medical societies.

Discussion with the Workmen's Compensation Fund have met with resistance, and if further evidence develops that it is willing to carry on fruitful discussions, we stand ready to discuss our position on usual and customary charges. We feel it is in the best interest of the employers and their employees that workers receive the highest quality of care to shorten their period of disability and to return them to their jobs after the fullest degree of care and rehabilitation. We are

firmly convinced that the employers, the employees and their unions expect quality care and recognize that for quality service the physician is justified in billing his usual and customary charge.

Our negotiations will continue with all agencies and parties in a fair and impartial manner in keeping with our progressive medical economic policies.

Cooperative Long Range Planning

So frequently in the past medicine has been criticized as not being *for* anything but always *against* any proposal. As many such unjust accusations are often based on opinion rather than judgment, it is true that we are often placed on the defensive by not cooperating with other agencies in long-range planning or by not conducting our own studies relating to our development and future needs.

We are fortunate in having on our state staff Mr. Edward D. Hagan, who has demonstrated considerable interest and talent in carrying out several investigative studies that have produced a more accurate picture of our composition and statistical structure. One study established the fact we have had a net loss of 75 doctors in the past five years, which is a faster rate than our population loss. It was broken down by medical society areas which points to where our greatest problems exist. Another study refutes the fact that few men are going into general practice, as his study revealed that in the three age groups selected, 25-45, 45-65, 65-85, one-third of each group classified themselves as general practitioners.

Many past presidents as well as many of our physicians and citizens have long concerned themselves with our critical doctor shortage. It was with considerable satisfaction when Gov. Hulett C. Smith appointed his Task Force on Health, and charged it to explore the obvious shortage of doctors and medical personnel and facilities in our rural areas. He asked the Task Force to study the pressing need for new facilities for long-term care, mental health, and public health services in every section of the State. Particularily, he asked the Task Force to study the relationship among the West Virginia University Medical Center, the State Health Department and local health bodies and our public institutions.

The Governor, in his wisdom, recognizes that the State cannot forge forward to meet its rightful place of excellence until we provide our citizens with the highest quality of health and housing. Upon this strong base will be built a growing and expanding economy to support the needs of our oncoming generations.

The doctors of the State welcome the opportunity to cooperate with Governor Smith, the Task Force on Health, and the concerned and knowledgeable experts, to arrive at an evaluation of our needs, and to develop projects aimed toward an achievement of our goals.

As Chairman of the Sub-Committee on Health Manpower, I have prepared the following proposal under the sub-heading of:

Our Most Pressing Problems

A. Shortage of medical and paramedical personnel.

B. Shortage of qualified students and training programs.

C. Lack of mass direction to encourage students to go into the biological studies in high school to prepare them for training in the medical and paramedical fields.

D. Lack of financial return to stimulate interest in the paramedical fields.

E. Threat of control or regulation.

F. Reduced economic and cultural environment.

G. Need for developing more centers of medical service around existing major centers.

H. More unified planning to facilitate greater utilization of services.

I. Concerned and knowledgeable leadership amongst legislators, educators, community leaders, medical and allied health service personnel.

Recommendations

A. Expansion of our medical school with provision for staff, funds, and facilities for doubling our present enrollment of 60 to 120 in the freshman class of 1968.

B. Expansion and provision for pre-medical education in all of our state colleges of sufficient caliber to prepare our students of highest ability to make applications to medical schools.

C. Expand and elevate our internships and residencies to a level of excellence that will attract our medical school graduates.

D. Appropriation of state funds to provide scholarships at the undergraduate, postgraduate and internship level, and financial inducements to practice in communities that demonstrate the greatest need and ability to support these medical services.

E. Similar expansion of dental school and training facilities.

F. Increase professional and financial inducements for registered and practical nurses.

G. Provision for greater training opportunities in and out of hospitals for nurses aids and auxiliary personnel.

H. Development of high school curricula in biological and allied sciences by state and county departments of education.

I. Expanded and correlated broad spectrum programs at all state colleges.

J. Expanded and area correlated training programs by regional hospital councils.

K. Development and expansion of definite training programs for the many ancillary health workers either in high schools, trade schools, business colleges, junior colleges or colleges.

L. Community development programs supported by state and/or federal funds, or from private sources, to make the economic and cultural environment more attractive.

The work of the Task Force will continue until the final report to the Governor in November. It will then require his executive decision as to what portion can be implemented and what recommendations he will make to the Legislature. We are indeed fortunate to have such a knowledgeable Governor so concerned in the expansion of health services, and we trust that he will continue to consult actively with the medical profession.

Study and Reorganization of the Councilor Districts

This was primarily covered in the section on county medical societies and need not be restated except to emphasize that as the strength and organization of the county medical societies is fostered so will the purpose and ability of the State Medical Association be enhanced.

Paramedical Responsibilities

As spokesman for the West Virginia State Medical Association, I had the opportunity and pleasure to represent you on many occasions. I had the honor to speak before many groups, including the Rural Health Conference; the Licensed Practical Nurses convention; the West Virginia Bar Association; Sigma Delta Chi, the honorary journalism society; the Honor Students Seminar of Salem College; and many other groups and meetings on Medicare. One of the outstanding pleasures for the President is to address the medical students at Morgantown and the women of our Auxiliary.

Our Woman's Auxiliary

For many years I have held our ladies in the highest esteem and recognize that we owe them so much for their dedicated devotion and outstanding work. This year was certainly an exceptional one under the dynamic leadership of Mrs. Wilson P. Smith. "Maida" entered her responsibilities with a zest and zeal that has been an inspiration to all who have had the pleasure of working with her. Her unstinting and self-sacrificing effort has carried her to all sections of the State to stimulate greater activity and participation on the part of the county auxiliaries. Her driving goal was to win an outstanding award for our State in the amount of participation in AMA-ERF. Her efforts brought about a marked increase in contributions and West Virginia was awarded second place in its category. The Auxiliary certainly deserves our heartiest congratulations.

Following Doctor Esposito's recommendation, the Council showed its support of the Auxiliary by voting additional financial support of its convention expenses which will remove the necessity for an increased registration fee. It has been recommended that another forward step would be the inclusion of the Auxiliary dues at the time that the county medical societies bill their members. Several societies are already following this procedure.

In conclusion, I feel we have taken several important steps to strengthen our county medical societies and to draw together our organization into a more efficient and effective body to meet the problems of tomorrow. We are well endowed by many capable and loyal physicians throughout our State. In their combined efforts we can face our problems from a position of strength and confidence. We are indeed fortunate in having those men who will accept the responsibility of leadership and it is with pleasure and confidence that I turn over the reins of office to my friend, Dr. Richard E. Flood.

To those many, many friends who have given me such necessary support, and without whom this job could not be accomplished, please accept my sincerest thanks. I wish to thank you all for the opportunity you gave me to serve my fellow physicians and our great organization.

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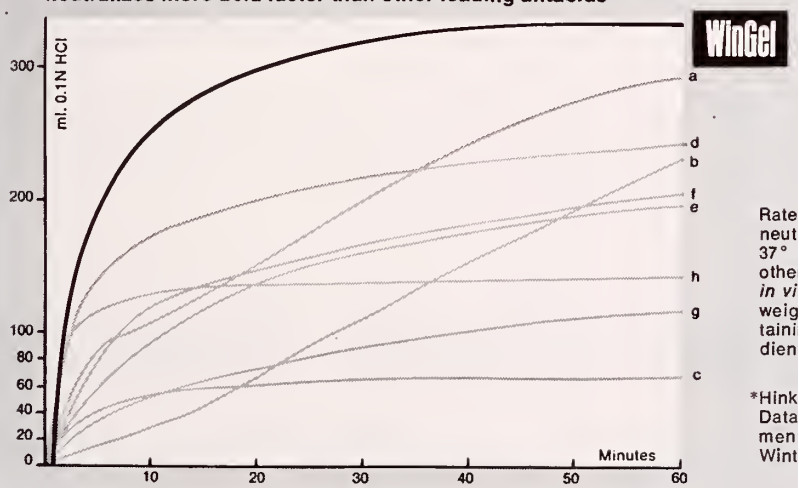

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*Hinkel, E. T., Jr. (New York): Data in the files of the Department of Medical Research, Winthrop Laboratories.

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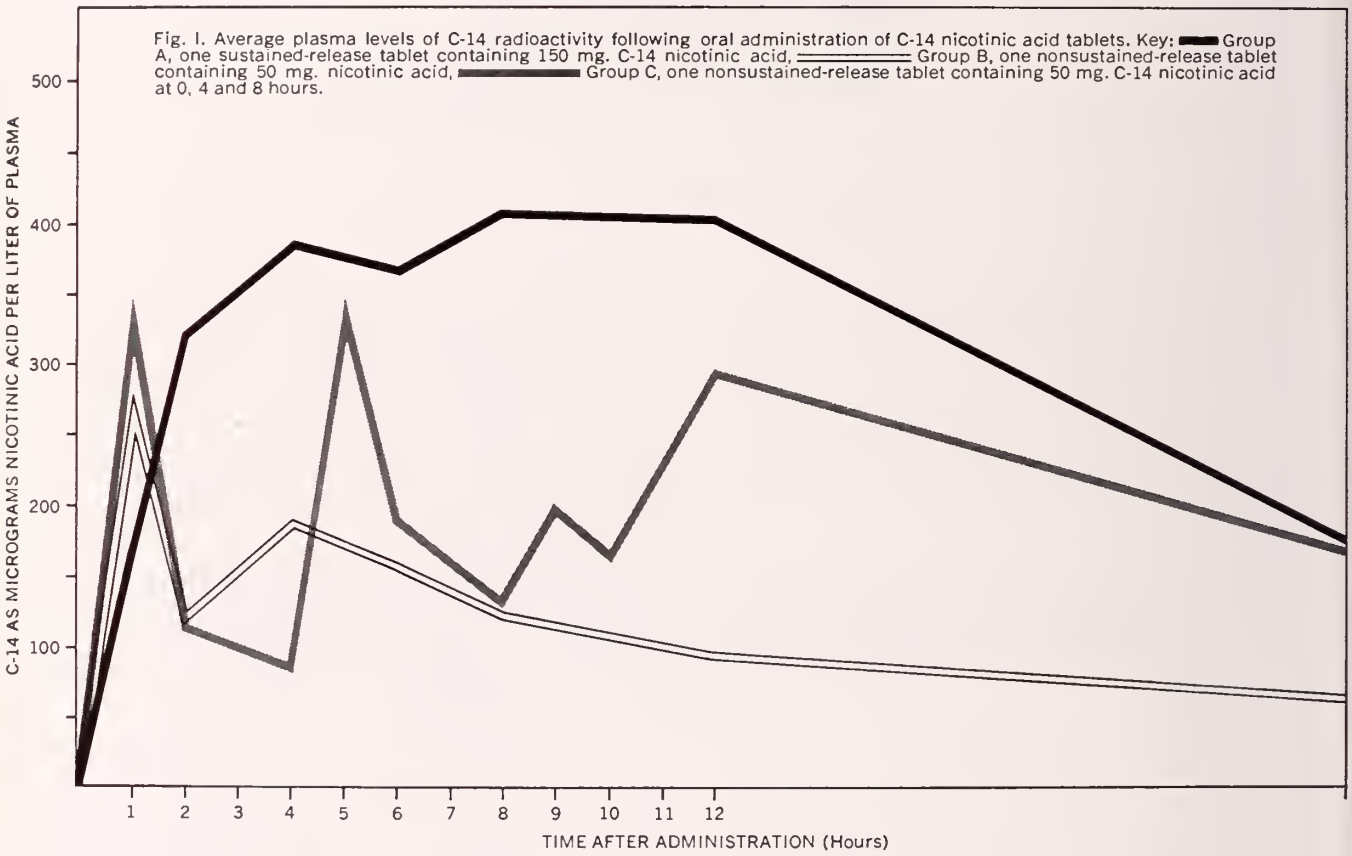

(fewer absent doses by absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

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Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

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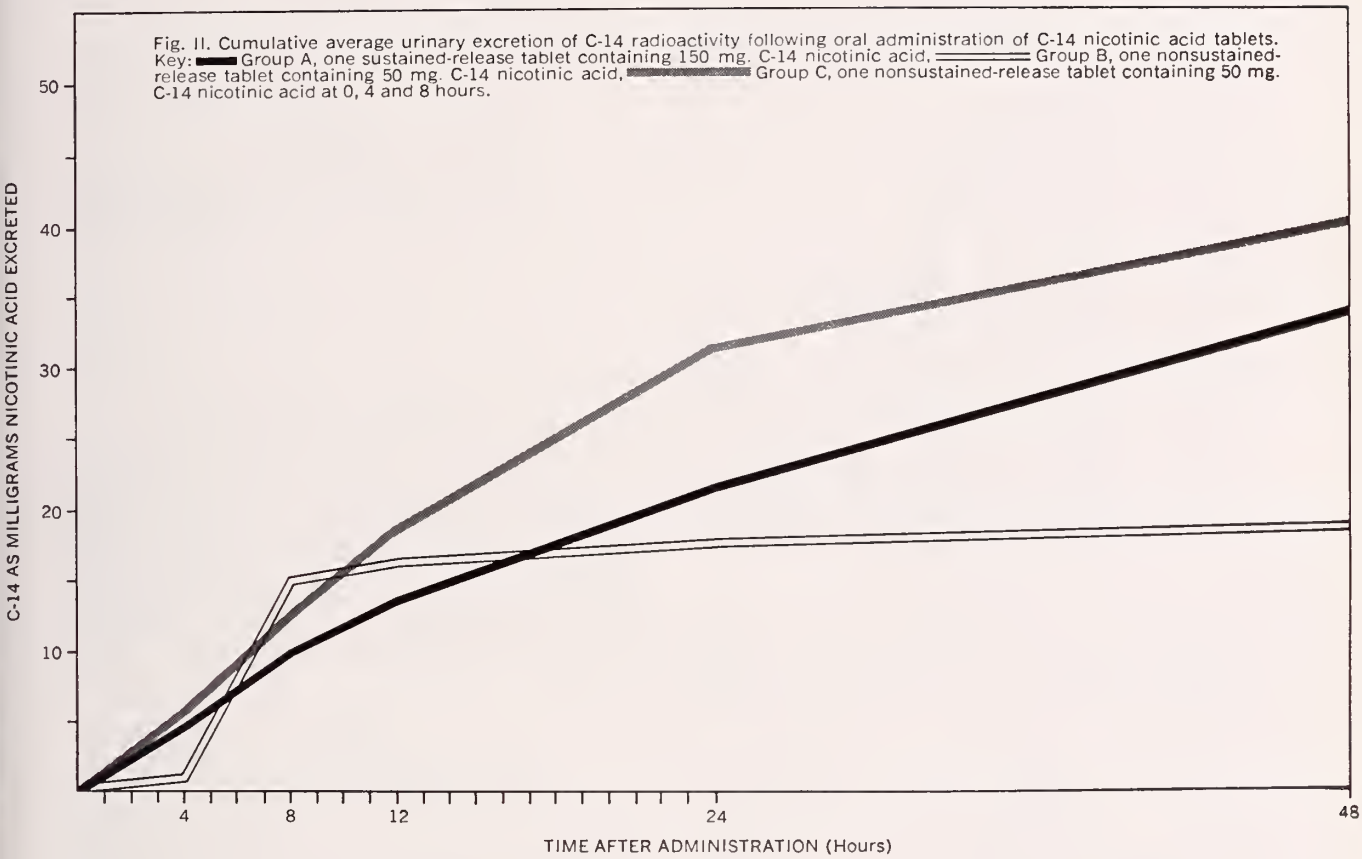

less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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West Virginia University Hospital Experience with Lung Cancer (1960-1965)

Richard A. Currie, M. D., and Charles E. Andrews, M. D.

PRIMARY bronchogenic carcinoma has been the single most frequently seen neoplastic disease at West Virginia University Medical Center since opening of the hospital facility in 1960. The incidence of new cases has shown a steady increase which has paralleled the increase in the annual number of hospital admissions (Figure 1).

Because lung cancer represents a serious problem both with regard to early diagnosis and adequate surgical treatment, it is believed that presentation of an analysis of our experience with it over the past five years is warranted. It is hoped that the conclusions drawn therefrom may be of value to those of you in West Virginia who are directly concerned with case-finding, and with decisions concerning the management of patients already victimized by the disease.

Composition of the Series

A review of our material shows that during the five-year period from September 1, 1960 to August 30, 1965, 295 new cases of primary bronchogenic carcinoma were observed and treated at the Medical Center (Table 1).

Of this number, 21 cases in which histologic proof of diagnosis was lacking have been included in the present series to allow for as complete a picture of the disease as it is reasonably possible to obtain.

In all of our unproven cases, a combination of clinical and roentgenologic observations which firmly supported the diagnosis was made manifest. In most of these cases there were tumors beyond reach of the bronchoscope and the stage of the disease itself was too far advanced on first admission to allow for confirmation of diagnosis by thoracotomy.

Males Preponderant

In the series of 295 cases, the usual preponderance of males was apparent, with the ratio of males to females falling in the neighborhood of nine to one (9 : 1). Of the entire group of 295 patients, however, only one was a Negro and, of course, a male.

Submitted to the Publication Committee, March 28, 1966.

The Authors

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- **Charles E. Andrews, M. D., Professor of Medicine, West Virginia University School of Medicine, Morgantown.**

Early Symptoms and Their Duration

On reviewing the charts of 265 hospital patients, the data contained in the medical history of each appeared adequate. A review of these same hospital records brought to light the fact that in over 60 per cent of cases cough, or chest pain, or hemoptysis had appeared as the first symptom of the disease (Table 2).

Table 1

Primary Bronchogenic Carcinoma W.V.U. Medical Center 1960-1965.

	No.	*Per Cent*
Cases with histologic proof	274	92.9
Cases with clinical and/or x-ray evidence	21	7.1
Inoperable patients	184	62.4
Operable patients	111	37.6
Males	263	89
Females	32	11
Total Cases	295	100.0

Table 2

First Symptoms	*No.*	*Per Cent*
Cough and Expectoration	82	30.9
Chest Pain	63	23.7
Hemoptysis	30	11.3
Shortness of Breath	29	10.9
Weight Loss & Anorexia	19	7.2
Abnormal Chest X-ray (Asymptomatic)	9	3.3
Symptoms from Distant Metastases (Hoarseness, headache, back pain, etc.)	33	12.4
Total	265	100

In only nine cases, or 33 per cent, was the diagnosis made by chest x-ray alone and with the patient in an asymptomatic stage of his illness.

In 33 cases, the first symptom could have been a result of metastases or mediastinal extension of the tumor prior to the appearance of primary pulmonary symptoms.

The average interval between appearance of the first symptom and admission to hospital was 4.5 months. The interval was three months in cases in which the disease was operable, as compared with 5.5 months for inoperable cases.

Age and Tumor Type

Ages of the patients in our series ranged from 29 to 85 years, with an average age of 59.4 years. The 32 female patients had an average age five years younger than that of the males. Approximately three-fourths the number were in the sixth or seventh decade of life when first admitted (Figure 2).

The predominant histologic type of tumor could be determined in 262 cases in which the pathologic specimen was adequate for the purpose. The relative frequency of each type is indicated in Table 3. Twelve examples of oat cell carcinoma are included in the category of anaplastic tumor. It will be seen that the highest rates of operability were associated with tumors classified as adenocarcinoma or squamous cell carcinoma. Forty-seven, or 60 per cent, of the resectable tumors were classified as squamous cell carcinoma.

Diagnosis and Assessment of Operability

Throughout the five-year period it was our policy to follow a plan of investigation in each case which gave, when possible, a definite histologic diagnosis prior to consideration of thoracotomy, as well as a careful assessment of the preoperative status in regard to risk. Bronchoscopy and scalene lymph node biopsy were applied in liberal fashion throughout the period of study. Standard criteria such as existing distant metastases, proof of involvement of recurrent nerve, extension of tumor to the superior sulcus, the superior vena caval syndrome and pleural effusion associated with positive cytology were used in the definition of inoperability. In addition, advanced age, poor cardiopulmonary function and the presence of serious associated disease were considered in relation to degree of surgical risk and to extent of pulmonary resection planned after assessment of operability is made.

One hundred eighty-four patients (62.4 per cent) were classed as inoperable, three-fourths the number on the basis of demonstrable metastases and the remaining fourth because of advanced disease, high operative risk or refusal to undergo surgery. The great majority of the 37 cases in which the patients were classified as poor risks were in the upper age groups. In no case was inadequate pulmonary function

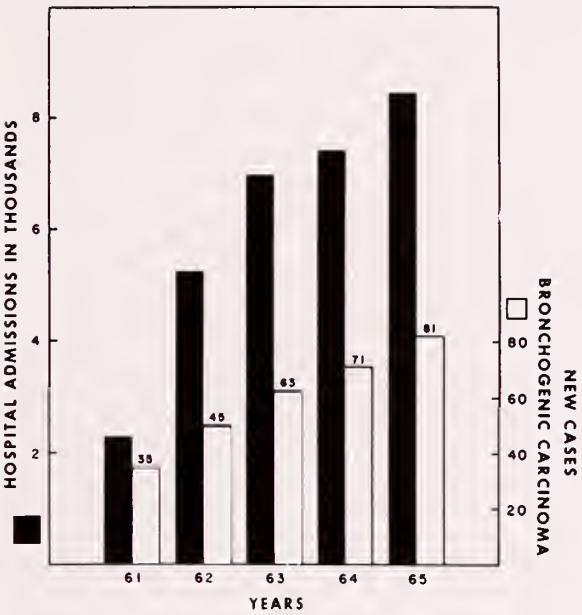

Figure 1

Annual incidence of new cases of lung cancer at WVU Medical Center compared with annual hospital admissions.

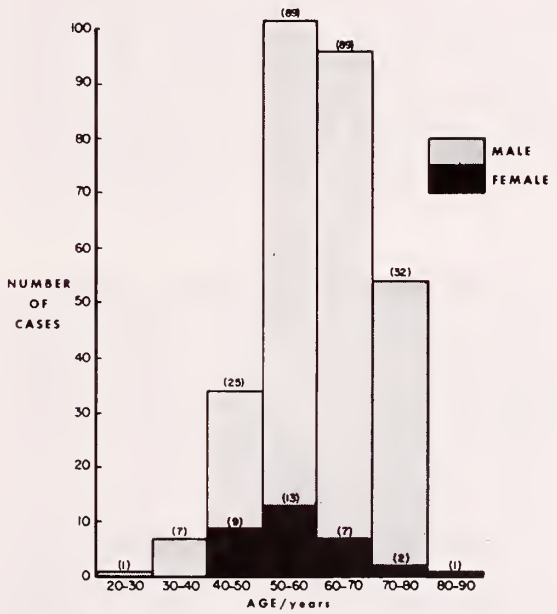

Figure 2

Age distribution of new cases of lung cancer in males and females 1960-65.

alone advanced as a reason for inoperability (Table 4).

Bronchoscopy was accomplished in 213 of the 295 cases. Positive bronchial biopsy specimens were obtained in 58 cases or 27.2 per cent. One hundred eighty-three scalene lymph node biopsies, 26 of them bilateral, were carried out in the series. Evidence of extension of disease to nonpalpable scalene lymph nodes was obtained in 29 cases, or 15.7 per cent. No serious complications and no deaths were attributed either to bronchoscopy or to scalene lymph node biopsy, the latter performed in all instances, using local anesthesia and, oftentimes, in conjunction with the other.

Analysis of the sites of metastases, as shown in Table 5, indicates that in 25 per cent of cases with proven metastases, there was local extension of the tumor within the chest and in 75 per cent there were distant, extrapulmonary metastases. Biopsy examination of cutaneous nodules yielded a significant number of histologic diagnoses in cases of patients with advanced disease. Biopsy of palpable cervical nodes was accomplished in 25 cases and furnished positive proof of metastasis in 22. In approximately 20 per cent of the entire series of 184 inoperable cases, there were at least two criteria for inoperability demonstrated during the patient's first admission.

Selection of Treatment

In the majority of inoperable cases, the disease obviously was in an advanced stage at the time of first admission. In 52 cases, or 28.2 per cent, death occurred during the first hospitalization. Of the 184 cases judged inoperable, the patients in 78, or 42 per cent, were given x-ray therapy. Indications for palliative x-ray therapy included painful metastases, Pancoast syndrome, superior vena caval obstruction, severe hemoptysis and intractable cough. In a considerably smaller group, the patients received chemotherapy, usually in the form of intrapleural nitrogen mustard, for control of pleural effusion.

Treatment of the 111 patients with operable disease is summarized in Table 6. In 32 cases, or 28.8 per cent, unresectable tumor was established at exploratory thoracotomy, the unresectability usually due to previously unrecognized mediastinal extension and, occasionally, to widespread pleural involvement. Resection was carried out in 79, or 71.2 per cent of cases comprising the operable group. There were 28 lobectomies and 51 pneumonectomies. Twelve resections could be described as "extended," involving removal of portions of the chest wall, the pericardium, the atrium, the great vessels, or the carina because of the local extent of disease encountered.

Mortality Rates

In the operable group, there were 16 deaths, an over-all mortality rate of 14.4 per cent, when deaths occurring in a 30-day period following operation are included. The mortality rate was highest in the group that had "fruitless thoracotomy." Of the seven postoperative deaths in the unresectable group, four could be attributed to atelectasis and infection in poorly expanded lungs associated with obstructing tumors. In two cases, death was due to complications of duodenal ulcer, and in one case it was due to intractable hemoptysis.

Fatal complications in patients undergoing resection were more frequent in those having

Table 3

Tumor Classification In 274 Proven Cases

Type	*Inoperable*	*Operable*	*Total*	*Per Cent*
Epidermoid	70	59	129	47.0
Anaplastic	58	31	89	32.4
Adenocarcinoma	19	19	38	13.8
Alveolar	4	2	6	5.3
Unclassified	12	0	12	10.5

Table 4

Basis For "Inoperability" In 184 Patients

	No.	*Per Cent*
Demonstrable metastases	138	75
Terminal state	23	12.5
Age, debility, assoc. disease	14	7.5
Refusal to undergo operation	9	5

Table 5

Sites Of Proven Metastases In 138 Patients

Local Extension		*Distant Metastasis*	
Pleura or chest wall	12	Scalene nodes	29
Superior sulcus	7	Cervical nodes	22
Superior vena cava	4	Bones	16
L. Recurrent nerve	6	CNS	16
Carina	4	Skin	10
Esophagus	1	Abdominal lung	8
		Opposite lung	3
Total	34	Total	104
Per Cent	25	Per Cent	75

Table 6

Surgical Treatment Of Lung Cancer In 111 Operable Patients 1960-1965

Operation	*Number*	*Per Cent*	*Operative Mortality*	*Per Cent Mortality*
Exploratory Thoracotomy	32	28.8	7	22
All Resections	79	71.2	9	11.3
Lobectomy	28	35.4	3	10.7
Pneumonectomy	51	64.6	6	11.7
Extended Resections	12	15	4	33.3
Totals	111	100	16	14.4

extended operations than in those having standard lobectomy or pneumonectomy. The nine deaths included one due to hemorrhage occurring during operation, three cases in which it was due to cardiac arrest in the early postoperative period; three were due to cardiorespiratory failure, one to pulmonary embolism and one to complications of bronchopleural fistula.

Follow-Up Data

Follow-up of the 132 inoperable patients leaving the hospital in January, 1966, has shown that three patients cannot be traced; that one was living, two years following a course of palliative x-ray therapy and that the remaining patients are known to be dead. The longest survival in the group was 39 months, observed in the case of a patient with Pancoast syndrome, who was treated by x-ray therapy. In only eight inoperable cases did the patients survive longer than 12 months following their first admission; and the average survival was 3.9 months following hospital discharge.

Of the 32 patients with unresectable tumors, 29 are known to be dead of disease, their average survival time being three months. The three survivors include one patient who has lived nearly three years following completion of x-ray therapy.

Of the 70 patients leaving the hospital after resection, 26 are living and apparently well; two others are living, with evidence of metastatic disease; one patient is untraced and 41 are now known to have expired. Thirteen of the survivors of resection have lived longer than two years; eight of these have survived three or more years following operation. Late deaths due to disease in the resected group have been extremely infrequent after a two-year interval from the time of surgery. The great majority of the 41 late deaths occurred in the first 15 months following surgery. No patient in the series is known to have survived five years or longer.

Discussion

The picture that emerges from this analysis is discouraging insofar as early diagnosis and effective treatment are concerned. The lateness of the disease, as it has presented in our series of cases, has been strikingly emphasized by the high hospital mortality rate, the frequency of multiple and extensive metastases, and the paucity of long-term survivors in the inoperable group. Further commentary on the advanced stage of the disease has been the frequency with which unresectable tumors have been discovered at exploratory thoracotomy and the need, in a significant number of cases, for operations of a magnitude greater than standard pneumonectomy or lobectomy, for successful removal of locally advanced tumors.

Early Diagnosis a Problem

Early diagnosis in bronchogenic carcinoma is the problem. In reviewing this experience we were impressed with the small number of cases in which the lesion was found by survey films during an asymptomatic interval. In the great majority of cases significant symptoms were manifest at the time of discovery, via x-ray, of a chest abnormality, and in a sizeable number of cases, the patients had had pulmonary symptoms for long periods of time preceding establishment of the diagnosis. In at least a third of the cases in the inoperable group, no chest x-ray had been performed in the five-year period preceding onset of symptoms. Obviously, wider use of x-ray screening procedures might have benefited some of these unfortunate individuals.

In the investigation of patients and the assessment of operability in certain cases, use of standard criteria and usual diagnostic procedures has proven satisfactory. Scalene lymph node biopsy in cases without palpable nodes appears to offer a means of discovery of occult metastases in approximately 10 per cent of the entire series. Biopsy of palpable cervical nodes also has been shown to be rewarding with regard to establishing the diagnosis, also proof of inoperability. In the group of 32 patients whose tumors were shown at operation to be unresectable the mortality rate was high. It would appear that further refinement of screening procedures and more stringent definition of operability, with avoidance of thoracotomy as a means of obtaining a histologic diagnosis in doubtful cases eventually should result in a significant reduction in the number of patients deemed unresectable at the time of exploratory thoracotomy.

Comment

In dealing with so small a number of patients and so limited a follow-up period, no sweeping conclusions concerning the accomplishment of surgery can be made. Resection was possible in only 26.7 per cent of the entire series of cases and was accompanied by a significant postoperative mortality, especially in cases in the group requiring extended resection. In general, death following surgical resection most commonly was due to cardiopulmonary complications, and especially was of more frequent occurrence in older patients and in those subjected to pneumonectomy. A downward trend in the operative mortality rate has been observed in recent

years, with the more frequent use of lobectomy in older individuals and with a more selective application of the techniques of extended resection.

Summary

A five-year experience with primary bronchogenic carcinoma at the WVU Medical Center is reviewed. Observations concerning diagnosis, assessment of operability, choice of treatment and hospital mortality are presented.

A brief recording has been made of the follow-up status of patients in the present series as of January, 1966. Comment on the need for earlier diagnosis, for refinement of screening procedures and for reduction in hospital mortality rates is offered.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.

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CONTRAINDICATIONS: Do not use in intestinal obstruction, extensive ulceration of bowel, or diverticulosis; in hypersensitivity to sulfonamides or neomycin; in pregnancy at term, in premature infants, or during first week of life in the newborn.

WARNINGS: Use only after critical appraisal in patients with hepatic or renal damage, urinary obstruction, or blood dyscrasias. Fatal hypersensitivity reactions and blood dyscrasias reported with use of sulfonamides. Consider periodic blood counts, hepatic and renal function tests during intermittent or chronic use.

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curare-like neuromuscular block during anesthesia if neomycin is used preoperatively in large doses when renal function is poor; watch for overgrowth of nonsusceptible organisms. Consider possibility of ototoxicity and nephrotoxicity with prolonged high dosage.

SIDE EFFECTS: As with all sulfonamides: Headache, malaise, anorexia, G.I. symptoms, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, rash, conjunctival and scleral injection, petechiae, purpura, hematuria, and crystalluria have been noted. Reduced fecal output of thiamine and decreased synthesis of vitamin K have been reported. *Neomycin:* Nausea, loose stools.

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where today's theory is tomorrow's therapy

Selective Coronary Cine-angiography*

Harold Selinger, M. D.

Many advances have been made in the understanding of coronary artery disease, yet little advance has been made in the diagnosis of this disease in the absence of myocardial infarction. The diagnosis has rested on a typical history of angina pectoris which is not different from that first described by Herrick, in 1919, to which has been added the therapeutic trial of coronary dilators. In some difficult cases, an exercise electrocardiogram, as described by Master,[1] in 1929, has been used. Unfortunately, there has been little agreement on the criteria[2] for a positive exercise test. Now the question of how much[3] exercise is necessary for an adequate test and whether electrocardiograms should be taken during, as well as after, exercise have made this test of questionable value to determine the presence of coronary disease. There is, therefore, a need for an accurate means of diagnosing coronary disease; and with the availability of satisfactory surgical procedures for intractable angina, there is a greater need for accurate appraisal of the coronary vasculature.

The obvious diagnostic test is one which visualizes the coronary arteries and can demonstrate coronary sclerosis. This technique has been available since 1933 when Rousthoi[4] and Reboul and Racine[5] described a technique of coronary angiography. Radner,[6] by 1945, first performed coronary angiography in a living man. In 1952, enough data had been collected on human coronary angiograms to allow Di Guglielmo and Guttaduaro[7] to publish their excellent monograph on human coronary angiography.

These techniques have undergone considerable evolution. Recently, Gensini[8] reviewed the history of this evolution. Initially, what Gensini calls the "random brute force" angiograms were used, with high pressure injections of large quantities of contrast material into the aortic root. This was later modified by timed diastolic pressure injections into the aorta. Later injections were made during cardiac arrest or cardiac slowing, and balloon catheters were used to retain the contrast material in the aortic root. These procedures all had their vogue, but they are all being replaced by the technique which Sones[9] first described in 1959. This involves the selective catheterization of each of the two main coronary arteries, using a special narrow tipped catheter to prevent occlusion of these arteries. The arteries are then individually and selectively opacified by hand injection of 3 to 6 cc. of 70 per cent hypaque in each of several views. The opacified coronary arteries are photographed on 35 mm. motion picture film, utilizing an image amplifier. These films can then be viewed in motion or in still frames and evaluated.

The Author

- **Harold Selinger, M. D., Director, Cardiac Catheterization Laboratory, Department of Medicine, Memorial Hospital, Charleston, W. Va.**

Using selective coronary cine-angiography, the coronary arteries are routinely and safely visualized. During cardiac motion the rigidity or flexibility of the coronary vessels is evident. Coronary sclerosis with or without stenosis or obstruction can be evaluated. Coronary spasm can be seen and, with the use of coronary dilators, the spasm can be eliminated. Coronary dilators also make coronary stenosis more evident since the normal portions of the vessels are dilated and the stenotic segments are not affected. Myocardial bridges can be differentiated both from spasm and stenosis since they fully dilate during diastole. In the presence of coronary disease, collateral vessels may be seen with retrograde filling of the obstructed coronary artery. Other abnormalities, such as coronary anomalies and coronary fistulae, can be demonstrated. Although not clinically significant at present, the coronary venous system, including thebesian vessels and coronary veins, can be visualized. This technique has also been used to evaluate the effectiveness of coronary dilators and coronary surgery.

In our laboratory, the indications for coronary angiography are as follows: (1) the evaluation of patients with bizarre or undiagnosed chest pain, (2) the evaluation of patients with known coronary disease being considered for surgery (in these cases the diagnosis is proved, the extent

*Presented before a Cardiac Symposium at Memorial Hospital in Charleston, January 20-22, 1966.

Submitted to the Publication Committee, March 16, 1966.

of the disease is evaluated, thereby allowing the surgeon to select the most advantageous surgical procedure); (3) the evaluation of patients being considered for aortic valve surgery so that the surgeon will know whether any anomaly of the coronary arteries exists to affect the placement of valves and; (4) the evaluation of adults being considered for open heart surgery (so that the extent of any coronary disease can be considered in the evaluation of the surgical procedure).

Change of Concept

Since we started coronary angiography almost three years ago we have changed our concept of coronary disease. We have found occasional patients, with what appeared to be typical angina pectoris apparently responsive to nitrates, to have normal coronary arteries. We have found patients, with chest pain quite atypical and unresponsive to nitrates, to have extensive coronary disease. Patients with apparently pure rheumatic heart disease have been found to have had coronary occlusions. Because of these findings, we now refuse to exclude the possibility of coronary disease when the pain is atypical in location, quality or temporal relationship. Nor are we absolutely certain that a patient has coronary disease when his symptoms are typical. Therefore, if there is any question of the cause of the pain, or if any serious change in therapy is contemplated, we recommend coronary angiography.

Perhaps in the future, coronary cine-angiography will be used routinely to decide which patients should be treated with diet, anticoagulants or other modalities of coronary therapy, rather than relying on the poor guidelines now in use.

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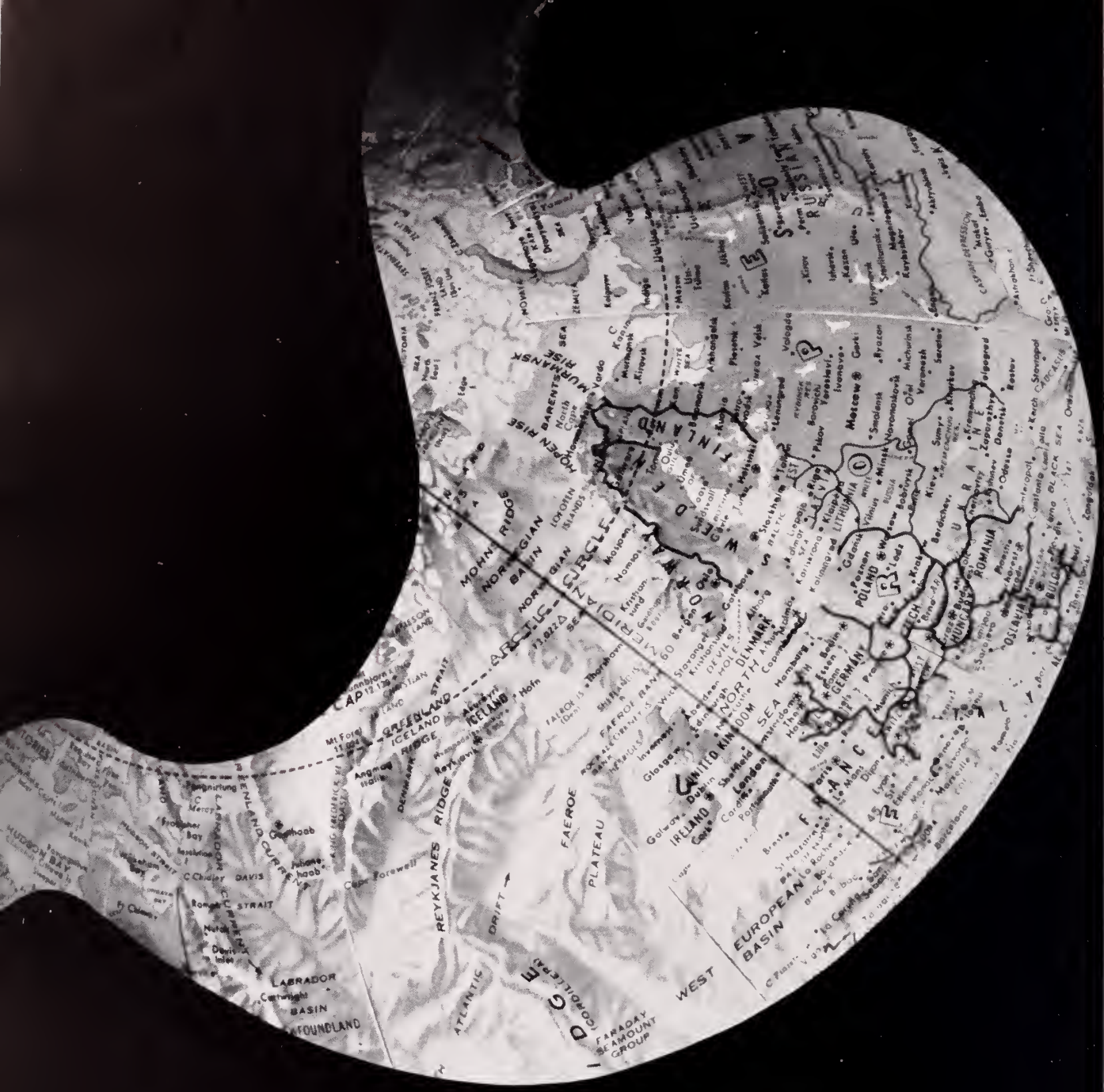
Dispensing the Sample

THE samples you get from drug companies are intended for one purpose: to be given to patients as a trial. However, if no written prescription accompanies the sample, the transaction looks like the dispensing of a home remedy; or looks as if the patient is being used as a guinea pig. Common sense suggests that the sample should be accompanied by a written prescription for the same item. It might be best to tell the patient: "This is a sample of a new (or good old) medicine that has had some fine results. If it is as favorable as I expect it to be, take the prescription to your neighborhood drug store so you can get more of this medicine. If you are disappointed in the result, call me."

This simple procedure will prevent the embarrassment of an otherwise satisfied patient trying to get the drug without a prescription. It will lift the medication into the dignified "prescription" class rather than make it look like a casual free sample. It indicates that the doctor is not going out on a limb, calling it a wonder drug. And it acts as an automatic (if not entirely scientific) check on the effectiveness and safety of a new drug.—The Journal of the Medical Society of New Jersey.



The "Socio-geographic" mystery

Why is one man's gastric ulcer another man's duodenal?

Geographic variation in the *incidence* of peptic ulcer is a familiar fact. But the proclivity of certain *kinds* of ulcer for certain geographic areas is a recently recognized phenomenon.[1,2]

For example, in one particular Norwegian fishing village there is a tendency for patients to develop a gastric ulcer; anywhere else in Norway, ulcers are usually duodenal. Peruvians high in the Andes have more gastric ulcers than their compatriots in the lowlands. Why? Nobody knows.

Social variations, too. Even in the same geographic areas there are interesting variations. An Englishman's ulcer depends on his social standing—professional men suffer with duodenal ulcers, while workingmen have more of the gastric variety. In southern India the pattern is reversed. Here, duodenal ulcers are common among laborers and agricultural workers and rare among the upper classes.

Investigators are exploring every possible theoretical avenue in their search for the cause of peptic ulcer. Of all the factors implicated in ulcerogenesis, the one that is generally acknowledged to be of primary importance is hypersecretion of gastric acid.[3-8] Or, as one author states it: "The medical management of peptic ulcer pharmacologically is, in the final analysis, concerned largely with the effective inhibition of peptic activity."[3]

Robinul (glycopyrrolate) provides potent, rapid, specific antisecretory action confirmed by gastric analyses and x-ray evidence of clinical effectiveness.[3,7,9–12] Relieves pain with "impressive" promptness.[8] Quickly alleviates acute discomfort, and effectively counteracts gnawing pain, preprandial midepigastric pain, belching and other ulcer symptoms.[7] Suppression of nocturnal pain is "outstanding."[13] Maximally effective doses may be given with minimal side reactions, and the incidence of unwanted anticholinergic effects is negligible.[3,7-14]

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Indications: In addition to its primary indications for duodenal and gastric ulcer, Robinul (glycopyrrolate) is indicated for other GI conditions that may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.
Contraindications: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.
Precautions: Administer with caution in the presence of incipient glaucoma.
Adverse Reactions: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.
Dosage: Dosage should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet 3 times a day: in the a.m., early p.m., and at bedtime. *See product literature for full prescribing information.*
Supply: Robinul (glycopyrrolate 1 mg.); Robinul Forte (glycopyrrolate 2 mg.); Robinul-PH (glycopyrrolate 1 mg.) with phenobarbital 16.2 mg. (Warning: May be habit-forming); Robinul-PH Forte (glycopyrrolate 2 mg.) with phenobarbital 16.2 mg. (Warning: May be habit-forming.) In bottles of 100 and 500 scored tablets.
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Special Article

The Tyranny of Medical Terms

E. J. Van Liere, M. D.

It is fair to assume that physicians, due to their long formal education, their intensive reading, and their cultural interests in general, can be regarded as scholarly individuals. Their rigorous scientific training has also taught them to be critically minded. It is known that people in the learned professions enjoy, on the whole, a more extensive vocabulary than does the average person; many physicians, furthermore, are discriminating in their choice of words. In view of these facts it is of interest to review critically certain medical terms which have insinuated themselves firmly in the medical literature, and indeed, some of them in the literature read by the average layman.

Let us give a few examples to indicate what we mean when we speak of the tyranny of medical terms. The word "anemia" is a widely used one; it is derived from the Greek (*an*, negative or without + *haima*, blood). Etymologically the term literally means without blood. It is admitted that nearly everyone knows that this is not strictly true, nevertheless one need not be a purist to object to the word. It would be more accurate to substitute the Greek prefix *an* with one expressing less than normal, for example, *hypo* (*hypo* Gr., under or sub). The word, then would become hyponemia or subnemia or some such variant, and it would then be etymologically sound.

The word "anoxia" which still has a wide usage is actually not a good term. It, too, is derived from the Greek (*a*, without or negative + *oxys*, oxygen); it literally means without oxygen. This is not the intended meaning of the word, so it is not without objection. A person may suffer from anoxia at an altitude of 10,000 feet, but will suffer still more at 14,000 feet. Since there may be degrees of anoxia a more accurate term is hypoxia (Gr. *hypo*, under or sub + *oxys*, oxygen); etymologically the word hypoxia clearly indicates that there is less than a normal amount of oxygen present. Fortunately the word has been widely accepted in the medical literature, and is gradually replacing the word anoxia.

Submitted to the Publication Committee, May 10, 1966.

The Author

- **E. J. Van Liere, M. D., Dean Emeritus, West Virginia University School of Medicine, Morgantown.**

A still more debatable word is "asphyxia" which is also derived from the Greek (*a*, without or negative + *sphyxis*, pulse); its true meaning, then, is without a pulse. Etymologically it should be used only in that sense. A person who died, for example, of ventricular fibrillation actually died of asphyxia, because his heart stopped beating. The difficulty is, however, that the word asphyxia as used in the literature is associated with respiration. Currently when death by asphyxia is mentioned it is assumed that death was due to respiratory failure. It is true that respiration generally ceases before the heart stops beating, but we repeat, the word asphyxia does not allude to respiration, but to the pulse. There is not much that can be done about this word since it is so widely used and accepted. It probably will continue to be employed indefinitely.

Another term which is misleading is "arcus senilis" which concerns an opacity of the peripheral cornea due to the deposition of certain fatty substances on the surface membrane and stroma of the cornea. The term is rather euphonious, and it has that in its favor, but it clearly signifies that it is found only in old people. It is true that it is seen more often in older people, but it may also be found in relatively young individuals. More appropriate terms have been suggested, namely "arcus lipoides cornea" or "corneal arcus."[1] These terms are more descriptive and more accurate since they do not suggest that an arcus is necessarily associated with old age. The term "corneal arcus" would more likely be accepted because of greater simplicity.

Many sesquipedalian words, such as diadochokinesis, adiadochokenesis, milliequivalents, and milliosmols probably are considered by some as splendid examples of the subject of our essay, the tyranny of medical words. This, however, is not necessarily true. Most of these words are well grounded etymologically. Let us examine, for example, diadochokinesis; it is derived from the Greek (*diadochon,* succeeding, and *kinesis,* motion). The word is defined in a medical dictionary (Dorland's 23rd ed. W. B. Saunders Co.) as "The function of arresting one motor impulse and substituting for it one that is diametrically opposite." The word adiadochokinesis (*a*, negative or without)is most frequently used. This condition may be defined as inability to perform rapidly alternating movements. This term seems an atrocious one, especially to those who have not studied the Greek language. The difficulty is that we would be hard pressed to replace it. Certainly it is easier to use the word adiadochokinesis than to explain that there is interference with the ability of a patient in making rapid alternating movements. The terms milliequivalents and milliosmols need no defense. It is, then, not the length of the word that makes it tyrannical, but rather the fact that its etymological origin is disregarded.

In the final analysis, any effort to change a medical term meets with an almost insuperable barrier. Whether the original word is good or bad does not seem to matter; it is so firmly entrenched in the medical literature, and often in the lay literature, that it is most difficult to replace it, regardless of the appropriateness of the new term. This does not mean, however, that no effort should be made to strive for a more accurate and descriptive term and one which is solidly grounded etymologically.

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Who Makes the Drugs You Use?

I need hardly remind physicians that trade names usually are much more easily identified and remembered than generic but have the disadvantage that the same drug appears under a variety of trade names. Usually the physician sticks to the name he remembers and the company he trusts.

Are trademarked drugs more reliable? In general yes, because the maker is identifiable. Generic name use tends to encourage the fly-by-night manufacturer who all too often sells drugs for legitimate use through the front door and to the rackets through the back. I would rather pay more for a trade-name amphetamine than a cheaper amphetamine tablet which may largely participate in the goofball market. And there are drugs, such as digitalis, that I would not dare use without knowing who made them.—Irvine H. Page, M. D., in *Modern Medicine.*

Many overweight patients can benefit from the appetite control provided by the sustained anorexigenic-tranquilizing action of BAMADEX SEQUELS: anorexigenic action of amphetamine; tranquilizing action of meprobamate; prolonged action through sustained release of active ingredients.

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Contraindications: Dextro-amphetamine sulfate: in hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneuratic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, practitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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A message from . . .

The President

COMMUNITY HEALTH WEEK

One of the many new services made by the AMA in the last few years is the establishment of Community Health Week. As yet, the idea has not caught on in West Virginia. At this late date, prodding will not do much good, although anyone who *really* wants to *could* arrange some activity for the week of October 16-22, 1966. Try it! It may be fun as well as a good public relations act—Lord only knows our image could be improved in the eyes of John Public (and his Mrs. ! ! !). Come to think of it, the Woman's Auxiliary would be the best prodder Community Health Week could have—any takers from my adopted harem?

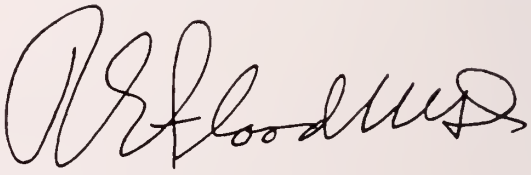
I visited Harrison County, more specifically Clarksburg. What a wonderful place to start off my county visiting! They are extremely friendly and kind people, and many thanks to all who came out, boys and girls! And thanks to Jim Thompson and family who entertained all the Auxiliary and spouses and me in their lovely home high on the hill.

Now I'm looking forward to our county visits, and I'll go anywhere I'm asked to go as long as I can plan ahead.

I took in the AMA meeting on Rehabilitation in Chicago. The proceedings I'll try to assemble as they are unfolded to me and report in detail later. Let it be said, however, rehabilitation has become *the* big item and is included in *all* titles of the Social Security Act. We always plan rehabilitation with all of our patients—from the dandruff to the most severe malady. We always have and always will, for that's the art of Medicine. Rehabilitation now is no longer physical medicine alone but is restorative and most emphasis falls on vocational rehabilitation.

At this writing, we are marking time on Title XIX and direct billing. *It is imperative that we stay with usual and customary charges that likewise are reasonable*—don't falter! ! ! ! It is so much easier to be kind and gentle—much safer for avoiding coronary spasm. Try hard and the honey reward will be more tasty than any vinegar!

Don't forget the Centennial—any news of old, in fact anything pertaining to Medicine and our Association will be gently handled and guarded with care and passed on to all as one big collection.



Richard E. Flood, M. D., *President*

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EDITORIALS

THE NEW PRESIDENT

As the Association enters its Centennial Year, we are pleased and consider ourselves fortunate to have as our new President a physician who has been closely identified with organized medicine for a number of years. He has devoted much time to the affairs of the Association and came up through the ranks before his elevation to the presidency.

Dr. Richard E. Flood of Weirton has always been considered the type of man to turn to if there is a job to be done. This is true not only in the case of the Association but also in his own community where he has been engaged actively in civic, educational and religious projects.

The year ahead promises to be an eventful one for the Association, and Doctor Flood has appointed a committee to make plans for a proper and fitting celebration of the Association's 100th year of existence. By this time next year we are sure we will have thanked Doctor Flood for a "job well done."

Doctor Flood was born in Glendale, Pennsylvania, the son of Mrs. Peter E. Flood and the late Mr. Flood. The family moved to Weirton in 1917. He was graduated from Catholic Central High School in Stubenville, Ohio, where he was captain of the football team.

Doctor Flood attended the University of Notre Dame, receiving a B.S. degree in biology in 1937. He received his M. D. degree in 1941 from Jefferson Medical College. He served an internship at Harper Hospital in Detroit and was a surgical associate of Dr. Clark D. Brooks of Detroit in 1942.

Richard E. Flood, M. D.

During World War II, Doctor Flood served for 42 months in the Medical Corps of the United States Army in England, Africa and the South Pacific. He was discharged in 1946 with the rank of Major and began the private practice of medicine in Weirton.

Doctor Flood is a past president of the Hancock County Medical Society and the Fort Steuben Academy of Medicine. His other professional memberships include the American Medical Association, the Southern Medical Association, the Fort Henry Academy of Medicine, the American Academy of General Practice, the American Public Health Association, the Industrial Medical Association, the Royal Society of Health and the American Geriatric Society.

Doctor Flood is coroner of Hancock County and serves on the Board of the Hancock County Health Department. An active churchman, he serves on the Tribunal of the Roman Catholic Diocese of Steubenville.

Doctor Flood served for four years as a member of the Council of the State Medical Association beginning in 1959. He was elected Vice President in 1964 and named President Elect in 1965. He was installed as President at the final session of the House of Delegates in August.

We are sure that all members of the Association will join with us in extending best wishes and our full support to Doctor Flood during his tenure of office.

CENTENNIAL YEAR 1867-1967

This is Centennial Year for the West Virginia State Medical Association—a time for retrospection and consideration of all the bounties of the past and a time to remind all physicians of the medical accomplishments of the present century and particularly of the 100 years of action of the West Virginia State Medical Association.

In due time, we are informed, a history of our Association will become available to you but before this may be accomplished it is necessary to collect all available historical references to our organization.

The Journal will devote extra space each month to the publication of information about county and state medical events of the past century. Any individual with such material is urged to send a copy of same to the state office or if the original manuscript is sent to *The Journal* it will be copied and the original promptly returned to the owner. *The Journal* is especially interested in events that occurred prior to 1906 which is the year of the establishment of *The Journal*. *The Journal* records are available from 1906 to 1966 in unbroken publications. Personal items concerning our doctors in the 19th Century are especially desired.

President Flood has appointed a large committee to develop a Centennial program. All news pertaining to the committee's activities will be published in *The Journal*.

This would be an excellent time for component societies to write their local medical history if such has not already been done. Abstracts of local society histories will be published if available and copies of the entire manuscript will be filed in the archives.

Doctor Flood wishes to have an exhibition of interesting objects pertaining to our medical historical activities. This may include programs, buttons, souvenirs and all manner of memorabilia. This collection will be shown at The Greenbrier at our 1967 Convention. Doctor Flood assures us that all such treasures will be properly housed, safeguarded and returned to the owners.

All such material, manuscripts and suggestions will be gratefully received.

COMMUNITY HEALTH WEEK

Community Health Week in 1966 is any week any state or community chooses to designate as such. It is an occasion for an inventory of your community's health resources. You may find some facilities that can be viewed with pride and you may have services that seriously require updating. For interested communities a survey form is available that will indicate your needs and your aims for the future.

This is the fourth annual observance of Community Health Week. Some areas have had an active annual program—some places have done nothing. Medical societies in particular need to emphasize medical advances, health resources and health problems and needs. This is the time to be sure you have used all the county, state and national resources that are available from a dozen sources to educate your people to the medical blessings that they may not now be receiving.

For physicians in West Virginia an array of material for radio, television and newspaper participation is available to you through your own component society, the headquarters of the West Virginia State Medical Association or the American Medical Association.

LUNG CANCER IN WEST VIRGINIA

This issue contains an important article concerning lung cancer in West Virginia. This disease kills more men over 45 than any other respiratory ailment. Most of us are familiar only with the fatal outcome of this disease but there is a small number of patients who may be salvaged if we are more concerned about the apparently innocent complaints of cough, sputum and chest pain, hemoptysis and shortness of breath.

The article states that many of the survey patients had had such complaints for an indefinite time prior to diagnostic study. It is true that the same conditions may occur with any ailment of the respiratory tract and in the vast majority of cases these simple complaints have an inconsequential etiology. So, it becomes necessary that all of us have some arbitrary point in the duration of illness, at which we consider x-ray, cytology, bronchoscopy and other definitive diagnostic procedures.

The tables indicate a high percentage of inoperability at the first medical consultation. This is not unusual even in the asymptomatic patient, or in the patient who was discovered in mass x-ray studies.

There is no known preventive measure for cancer. Prolonged cigarette smoking in the male over 45 years of age and cancer of the lungs have such a close association that it is our professional duty to advise all smoking patients to cease and desist. The physician should, also, support the non-smoking campaign, which is now a part of our educational system.

WHAT NOW— MR. AMERICAN CITIZEN?

The physicians of West Virginia were privileged to meet, talk with and listen to Dr. Charles L. Hudson, President of the American Medical Association, at our recent Annual Meeting. Our observations over several years' acquaintanceship with Doctor Hudson have led to but one conclusion—here is a man of knowledge, experience and understanding, who projects his personality and ideas in a quiet but forceful manner. Organized medicine will be well served during his tenure in office, and if they but heed and act, lasting benefits will accrue to the entire American populace.

In his recent appearance before our House of Delegates and guests, Doctor Hudson discussed the present and future problems which concern organized medicine. He displayed a well-defined sense of historical events which have transpired in many foreign countries, and which in America have finally led to the gestation and birth of a mis-begotten, politically-inspired, badly-planned makeshift called Medicare. Although we are inclined to place the onus of paternity entirely upon the shoulders of socialistically inclined politicians and labor leaders, Doctor Hudson very correctly identified the actions of certain segments of our citizenry as a primary etiologic factor. He noted the gradual transition in character from the rugged individualism of our forebears to the present generation which is willing to exchange their individual rights for a mess of pottage dealt out in a common trough from the paternalistic bureaucrats in Washington.

There can be no question as to the modus operandi of correcting this grievous social and economic error. In some way the general public must be made aware of their responsibilities, not only to themselves and their less fortunate brethren, but to future generations who must pay for our mistakes.

The Great Society has brought into general usage the word "consensus." Even our members of Congress depend upon the expressed opinions from "back home," and the only way these present trends which lead to the state of affairs described in "1984" can be reversed is by a preponderance of requests and demands made to individual congressmen by their clientele.

It is getting darker by the year, but it isn't too late yet for the light of knowledge and determination to eliminate the shadows of supine surrender of our most precious heritage. Each and every physician can play his most important role in his daily contact with his patients. Contributions to political action committees are needed for organizing and conducting political campaigns, but the ultimate result will ensue from personal contacts with the "folks back home."

In the meantime we wish Doctor Hudson well during his year as President and assure him that he will have the full support and cooperation of his colleagues in West Virginia.

No One Knows Like the Maker

When physicians encounter an adverse drug reaction it is not uncommon for them to write to the distributor of the drug, possibly in the form of a complaint or as a request for information on similar experience. Reports are often transmitted through the detail man. No one knows as much about marketing experience with a drug as its distributor.—Ralph G. Smith, M. D., in Journal of New Drugs.

GENERAL NEWS

Dr. Flood Installed as President Of State Medical Association

Dr. Richard E. Flood of Weirton was installed as President of the West Virginia State Medical Association during the 99th Annual Meeting at The Greenbrier in White Sulphur Springs, August 25-27.

The installation of Doctor Flood to succeed Dr. Seigle W. Parks of Charleston came at the second and final session of the House of Delegates on Saturday afternoon, August 27. Doctor Parks will automatically serve as Chairman of the Council for one year.

Dr. Seigle W. Parks (left), the retiring President, administers the oath of office to his successor, Dr. Richard E. Flood of Weirton.

Doctor Flood will preside over the Association during its Centennial. He announced that special plans are being made to mark the observance and that a special seal will be used.

Doctor Lynch President Elect

The House of Delegates named Dr. Richard V. Lynch, Jr., of Clarksburg as President Elect. He will be installed as President at the 100th Annual Meeting next year.

Dr. Richard W. Corbitt of Parkersburg, who has been a member of the Council for the past four years and has been serving as Chairman of the Committee on the Medical Aspects of Sports, was elected Vice President.

Doctor MacDonald Re-Elected

Dr. Kenneth G. MacDonald of Charleston was elected to his second one-year term as Treasurer of the Association.

Three New Members of the Council

Three physicians were elected to the Council to succeed members who had served four consecutive years on the Council and therefore were not eligible for re-election. The new Councilors and their predecessors are as follows:

Dr. S. Elizabeth McFetridge of Shepherdstown (Second District), who succeeds Dr. Charles L. Leonard of Elkins.

Dr. William E. Gilmore of Parkersburg (Fourth District), who succeeds Doctor Corbitt.

Dr. George R. Callender, Jr. of Charleston (Sixth District), who succeeds Dr. William B. Rossman of Charleston.

Doctors Gilmore and Callender are beginning their first terms on the Council; Doctor McFetridge had served previously.

Dr. Albert C. Esposito of Huntington, Chairman of the Council for the past year, automatically becomes Councilor-at-Large for one year.

Three Councilors Re-Elected

Three members of the Council whose terms expired were eligible for re-election and were elected to new terms. They are as follows:

Dr. G. Thomas Evans of Fairmont (First District); Dr. Andrew J. Weaver of Clarksburg (Third District); and Dr. A. J. Villani of Welch (Fifth District).

The following members of Council have one year remaining in their terms and were not subject to re-election:

Dr. Joseph L. Curry of Wheeling (First District); Dr. Maynard P. Pride of Morgantown (Second Dis-

Physicians from 22 States Attend Annual Meeting

Physicians from 22 states were in attendance at the 99th Annual Meeting at The Greenbrier in August. Registration records revealed that physicians traveled to White Sulphur Springs from as far as California, New Hampshire and Florida. Physicians also were registered from the following states:

Maryland, California, Florida, Georgia, Virginia, Ohio, District of Columbia, New York, New Hampshire, Illinois, Iowa, Kentucky, Pennsylvania, Connecticut, New Jersey, North Carolina, Alabama, Texas, Minnesota.

trict); Dr. R. L. Chamberlain of Buckhannon (Third District); Dr. I. Ewen Taylor of Huntington (Fourth District); Dr. Buford W. McNeer of Hinton (Fifth District); and Dr. W. P. Bittinger of Oak Hill (Sixth District).

Doctor Hoffman Re-Elected

Dr. C. A. Hoffman of Huntington was re-elected to a new two-year term as Delegate to the American Medical Association. Likewise re-elected was his alternate, Dr. D. E. Greeneltch of Wheeling.

Dr. Frank J. Holroyd of Princeton is the holdover AMA delegate, and Dr. Thomas G. Reed of Charleston is the holdover alternate.

Dr. Flood Born in Pennsylvania

Doctor Flood, the new President, was born in Glendale, Pennsylvania, and his family moved to Weirton when he was at an early age.

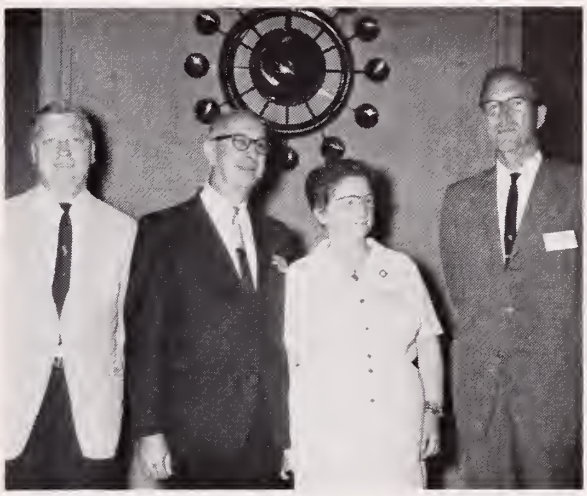
A graduate of Catholic Central High School in Steubenville, Ohio, where he was captain of the football team, Doctor Flood attended the University of Notre Dame, where he received a B. S. degree in biology in 1937. He received his M. D. degree from Jefferson Medical College in Philadelphia in 1941.

He received his internship training at Harper Hospital in Detroit and was a surgical associate of Dr. Clark D. Brooks of Detroit in 1942.

During World War II, Doctor Flood served for 42 months in the Medical Corps of the United States Army in England, Africa and the South Pacific. He was discharged in 1946 with the rank of Major and began private practice of medicine in Weirton.

Doctor Flood served four years as a member of the Council of the State Medical Association beginning in 1959, and was elected Vice President in 1964. He was named President Elect at the 98th Annual Meeting in August of 1965.

Doctor Flood is a Past President of the Hancock County Medical Society and the Fort Steuben Academy of Medicine. His other professional memberships include the American Medical Association, the Southern Medical Association, the Fort Henry Academy of Medicine, the American Academy of General Practice, the American Public Health Association, the Industrial Medical Association, the Royal Society of Health and the American Geriatric Society.



Dr. Seigle W. Parks (second from left), the new Chairman of the Council, is flanked by three newly elected members of Council, left to right: Dr. George R. Callender, Jr., of Charleston; Dr. S. Elizabeth McFetridge of Shepherdstown; and Dr. William E. Gilmore of Parkersburg

The President Elect

Doctor Lynch, the President Elect, is a native of Clarksburg. He attended West Virginia University, receiving an A.B. degree there in 1940, and earned his M. D. degree at the University of Pennsylvania in 1943. His specialty is internal medicine.

He interned at Presbyterian Hospital in Philadelphia and served a residency at Abington Memorial Hospital in Abington, Pennsylvania, during 1946-49.

These officers of the Association for 1966-67 appear to be in a happy frame of mind following their election and installation. Left to right: Dr. Richard W. Corbitt of Parkersburg, Vice President; Dr. Richard E. Flood of Weirton, President; Dr. Richard V. Lynch, Jr., of Clarksburg, President Elect; and Dr. Kenneth G. MacDonald of Charleston, who was elected to his second consecutive term as Treasurer.

Dr. Albert C. Esposito (right) presents the Past President's Plaque to Dr. Seigle W. Parks, the retiring President.

During World War II, he served as a Captain in the Medical Corps of the United States Army.

Doctor Lynch served four years as a Councilor beginning in 1960 and was named Vice President in 1965.

Resolutions Committee

The Committee on Resolutions held an open hearing on five resolutions filed with the Executive Secretary at least two weeks prior to the first day of the meeting. The committee meeting was held on Thursday afternoon, August 25, and was attended by several interested physicians in addition to members of the Committee.

The report of this Committee, which appears elsewhere in this issue of *The Journal*, includes the resolutions adopted by the House of Delegates at the second session on Saturday afternoon, August 27.

Addresses by Honor Guests

Three honor guests presented addresses at general sessions during the meeting.

Dr. Charles L. Hudson of Cleveland, President of the American Medical Association, spoke at the first session of the House of Delegates on Wednesday afternoon, August 24.

Hon. Hulett C. Smith, Governor of West Virginia, presented an address at ceremonies marking the formal opening of the convention on Thursday morning, August 25.

Dr. Edward R. Annis of Miami, Florida, a Past President of the American Medical Association, addressed an AMPAC-WESPAC meeting Thursday evening.

In addition, several noted authorities on medicine and surgery presented papers at general scientific sessions and at special meetings arranged by scientific sections, societies and associations affiliated with the West Virginia State Medical Association.

Amendments to the Constitution and By-Laws

The House of Delegates approved several amendments to the Constitution and By-Laws which had been approved by the Constitution and By-Laws Committee. The amendments which were adopted appear elsewhere in this issue of *The Journal*.

Dr. James S. Klumpp of Huntington served as Chairman of the Committee, and other members were Drs. G. Thomas Evans of Fairmont and Kenneth G. MacDonald of Charleston.

Address by Dr. Seigle W. Parks

Doctor Parks, the retiring President, presented his Presidential Address at the final session of the House of Delegates on Saturday afternoon. The complete text of Doctor Park's address appears elsewhere in this issue of *The Journal*.

Dr. Charles L. Hudson of Cleveland, President of the AMA (far left), and Gov. Hulett C. Smith (second from right) were among honor guests at the Annual Meeting. Escorting them to one of the sessions were Dr. Richard E. Flood, President (next to Doctor Hudson), and Dr. Frank J. Holroyd of Princeton, AMA Delegate. In picture at right, new officers of the West Virginia State Society of Allergy are shown with two speakers who addressed the Society's annual meeting. Front row: Dr. Marshall J. Carper of Charleston, Immediate Past President; Dr. W. L. Neal of Huntington, Vice President; and Dr. Robert S. Mutch of Fairmont, President. Back row: Dr. Paul F. deGara of New York City, guest speaker; Dr. Merle S. Scherr of Charleston, Secretary-Treasurer; and Dr. Victor L. Szanton of Derby, Connecticut, guest speaker.

Scholarship Winners Introduced

Dr. J. P. McMullen of Wellsburg, Chairman of the Committee on Medical Scholarships, introduced the two 1966 winners of the State Medical Association's $4,000 scholarships to the West Virginia University School of Medicine. They are Earl H. Eye, Jr., of Deer Run in Pendleton County and James C. Bosley of New Creek in Mineral County.

Each expressed his gratitude in brief remarks to the House of Delegates on Saturday afternoon. They are the thirteenth and fourteenth students to be awarded the scholarships since the program was inaugurated in 1958. Prior to 1962, only one scholarship was awarded each year.

Doctor Sleeth Presented AMA-ERF Check

Another feature of the final session of the House of Delegates was the presentation of a check in the amount of $14,287.73 to Dr. Clark K. Sleeth, Dean of the WVU School of Medicine. The check represented one year's contributions by West Virginia physicians to the School of Medicine through AMA-ERF.

1967 Meeting at The Greenbrier

The Council voted to conduct the Centennial Meeting of the West Virginia State Medical Association at The Greenbrier, August 24-26, 1967.

Total attendance for the 99th Annual Meeting was 715, which compares with 709 in 1965 and 627 in 1964. The physician registration was 408, compared with 442 last year. The Auxiliary registration was 211, compared to 182 in 1965, and the total registration of exhibitors and other guests was 96.

PG Course in Cancer

The American College of Physicians will sponsor a postgraduate course entitled "What the Internist Should Know About Cancer" in New York City, December 5-9.

Additional information may be obtained by writing to Dr. Edward C. Rosenow, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

Dr. J. P. McMullen (left) and Dr. Seigle W. Parks (right) are shown with 1966 scholarship recipients James C. Bosley (next to Doctor McMullen) and Earl H. Eye, Jr. In center is Mr. Bosley's wife, a school teacher. Doctor McMullen is Chairman of the Committee on Medical Scholarships.

Dr. Carr and Mr. O'Brien Win Bowling Tournament

Dr. A. A. Carr of Welch and Mr. Larry O'Brien of South Charleston came out winners in the Medical Bowling Tournament, which was held for the first time during the 99th Annual Meeting of the West Virginia State Medical Association at The Greenbrier, August 25-27.

Doctor Carr bowled 665 to take top honors in the handicap division. Dr. John P. Heagarty of Beckley was runner-up with 628.

Mr. O'Brien, a member of the staff of the West Virginia Heart Association, won first place in the scratch division with a score of 546. Dr. John M. Daniel of Beckley was second with 496.

Doctor Daniel, Chairman of the Tournament, said there were 16 entries.

Dr. James T. Priestley of The Mayo Clinic (center in left picture) presented papers before a general scientific session and the Section on Surgery. With Doctor Priestley are William E. Irons (left) and George B. Irons (right), both surgeons from Huntington. In picture at right, two guest speakers, Dr. Doris Howell of Philadelphia and Dr. William M. Deyerle are flanked by Dr. Carl B. Hall of Charleston (left), Chairman of the Program Committee, and Dr. Halvard Wanger of Shepherdstown, a member of the Committee.

Dr. J. P. McMullen To Direct Centennial Plans

Dr. Richard E. Flood of Weirton, President of the West Virginia State Medical Association, has appointed Dr. J. P. McMullen of Wellsburg as Chairman of the "Committee for 100," which will make plans for the observance of the Association's Centennial in 1967.

Doctor McMullen will be assisted by six members of the Woman's Auxiliary and several physicians who have been active in the Association for many years. They include 11 Past Presidents.

Physicians named to the Committee are: Dr. William L. Cooke of Charleston, Dr. Joseph L. Curry of Wheeling, Dr. Albert C. Esposito of Huntington, Dr. Thomas L. Harris of Parkersburg, Dr. George F. Evans of Clarksburg, Dr. E. Lyle Gage of Bluefield, Dr. Ray S. Greco of Weirton, Dr. D. E. Greeneltch of Wheeling, Dr. C. A. Hoffman of Huntington, Dr. Frank J. Holroyd of Princeton, Dr. James S. Klumpp of Huntington, Dr. Myer Bogarad of Weirton, Dr. L. J. Pace of Princeton, Dr. Seigle W. Parks of Charleston, Dr. Thomas G. Reed of Charleston, Dr. B. B. Richmond of Beckley, Dr. Edward J. Van Liere of Morgantown and Dr. Halvard Wanger of Shepherdstown.

Auxiliary members appointed are: Mrs. Hu C. Myers of Philippi, President; Mrs. Wilson P. Smith of Huntington, Immediate Past President; Mrs. Pat A. Tuckwiller of Charleston, Mrs. Myer Bogarad of Weirton, Mrs. Thomas L. Harris of Parkersburg, and Mrs. C. R. Davisson of Weston.

New Booklet on Gout

The Arthritis Foundation has published a 16-page booklet entitled "Gout: A Handbook for Patients."

Designed for laymen, the book discusses the cause, symptoms and treatment of gout.

Copies may be obtained by writing to The Arthritis Foundation, 1212 Avenue of the Americas, New York, New York 10036.

ACCP Offers Cash Awards In Essay Contest

The American College of Chest Physicians is offering three cash awards for the best essays prepared by undergraduate medical students on any phase of the diagnosis and/or treatment of chest diseases.

Beginning next year, the College Essay Contest will be known as the Alfred A. Richman Essay Contest because of a generous grant made by Doctor Richman, of New York City, Vice Chairman of the Council on International Affairs.

First prize will be $500; second prize, $300; and third prize, $200. Each winner also will receive a certificate of merit, and a trophy inscribed with the name of the winner and his school will be presented to the winner's school.

Winners will be announced at the 33rd Annual Meeting of the American College of Chest Physicians, which will be held in Atlantic City, New Jersey, June 15-19, 1967.

Official application forms and other information may be obtained by writing to Mr. Murray Kornfeld, Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago, Illinois 60611.

Cleveland Clinic Courses

The Cleveland Clinic Educational Foundation will conduct three postgraduate courses during October and November.

The courses and their dates are: "Update 1966—Selected Topics in Nursing," October 19; "Medical Technology," November 4; and Diagnosis and Treatment of Neuromuscular Disorders," November 16-17.

Detailed programs and other information may be obtained by writing to: Director of Education, The Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106.

Dr. Richard E. Flood (second from right in left picture), President, met with members of the Publication Committee during the Annual Meeting to outline his plans for the Association's Centennial Celebration next year. With Doctor Flood are (left to right): Dr. William L. Cooke of Charleston, Dr. James S. Klumpp of Huntington, Dr. Halvard Wanger of Shepherdstown, Associate Editors of The Journal; and Dr. George F. Evans of Clarksburg, Editor. Picture at right shows Dr. Asa Barnes of Beckley (left) chatting with Dr. Hawey Wells of Beckley, a scientific exhibitor.

ACP Regional Meeting In Washington

The American College of Physicians will hold a regional meeting for internal medicine specialists of Maryland and the District of Columbia in Washington on October 15.

The session, designed to keep College members abreast of developments in the basic sciences and clinical medicine, will be held in the Auditorium of the District of Columbia Medical Society Building in Washington, D. C.

Additional information may be obtained by contacting Dr. Thomas W. Mattingly, Washington Hospital Center, 110 Irving Street, N. W., Washington, D. C.

State Medicare Booklet Is Available

The State has published a 32-page booklet entitled "Medicare and You in West Virginia."

The publication—with a question-and-answer format—was prepared expressly for persons in West Virginia eligible for Medicare. It includes answers to specific situations regarding certified hospitals and clinics, medical payments, intermediary agents and welfare policies governing the Medicare program.

Nurses Group Awards Nine Scholarships

The West Virginia Professional Nursing Education Trust has awarded nine scholarships to students enrolled in accredited schools of nursing in the State.

The Trust is sponsored by the West Virginia Nurses Association. Four of the scholarships are new awards and five are renewed grants.

New grants were made for Anita Mae Burgess of Lewisburg and Patricia Ann Moore of Bridgeport, both enrolled at the Alderson-Broaddus College Department of Nursing in Philippi; Judy Ann Jackson of Pennsboro, Fairmont State College Department of Nursing; and Mrs. Juanita E. Lewis of Belle, Morris Harvey College Department of Nursing.

Scholarships were renewed for Carol Ann Williams, Charleston General Hospital; Linda Sue Holdren, Alderson-Broaddus College; Phyllis Ann Harrison and Sharon Jane Shreve, St. Mary's Hospital, Clarksburg; and Sharon Ann McCombs, Wheeling Hospital, Wheeling.

PG Course in Endocrine Disorders

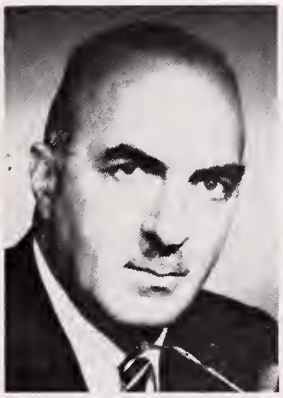
The American College of Physicians is sponsoring a postgraduate course in "Endocrine and Metabolic Disorders" in Brooklyn, New York, November 7-11.

Fees include $60 for ACP members and $100 for nonmembers.

Additional information may be obtained by writing to Dr. Edward C. Rosenow, Jr., Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania.

Four Physicians To Speak At Cabell Symposium

Speakers and their topics have been announced for the Cabell County Medical Society's Symposium on "Recent Trends in Diabetes," which will be held at the Hotel Frederick in Huntington on October 15.



George J. Hamwi, M. D.

Leo Krall, M. D.

The program is as follows:

"Physiological Factors and Pharmacologic Agents Affecting the Secretion of Insulin: Their Effects Upon Carbohydrate Tolerance"—John C. Floyd, Jr., M. D., Associate Professor, University of Michigan Medical Center, Ann Arbor.

"Pre-Diabetes and Prevention of Diabetes"—Leo Krall, M. D., Joslin Clinic, Boston, Massachusetts.

"Rats, Indians and Diabetes"—George J. Hamwi, M. D., Professor of Medicine, Ohio State University, Columbus.

"Peripheral Arterial Disease in the Diabetic"—Edwin C. Beven, M. D., Department of Vascular Surgery, Cleveland Clinic, Cleveland.

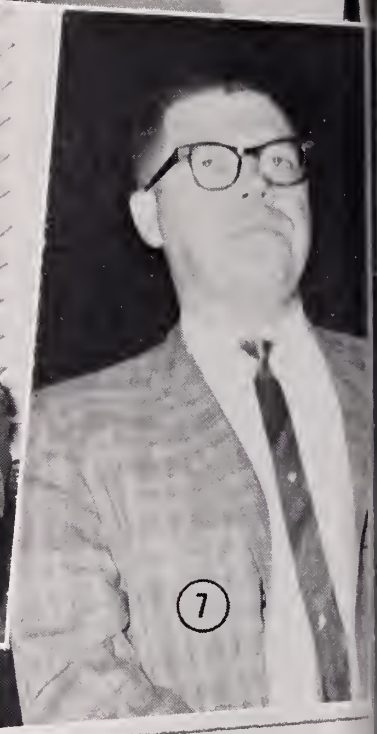
Dr. David A. Haught is Chairman of the Symposium. Additional information may be obtained by writing to Doctor Haught at 707 First Huntington National Bank Building, Huntington, West Virginia 25701.

Program Committee for 1967

Dr. Richard E. Flood of Weirton, President of the West Virginia State Medical Association, has appointed Dr. Ray S. Greco of Weirton as Chairman of the Program Committee for the 100th Annual Meeting of the Association, which will be held at The Greenbrier in White Sulphur Springs, August 24-26, 1967.

Serving on the Committee with Doctor Greco will be Drs. Richard W. Corbitt of Parkersburg, Vice President of the Association; Robert Greco of Morgantown; and Joseph D. Romino of Fairmont.

Doctor Flood also named Dr. J. P. McMullen of Wellsburg as General Chairman for the observance of the 100th anniversary of the Association.



CAMERA HIGHLIGHTS

99th Annual Meeting

WEST VIRGINIA STATE MEDICAL ASSOCIATION

The Greenbrier

August 25-27

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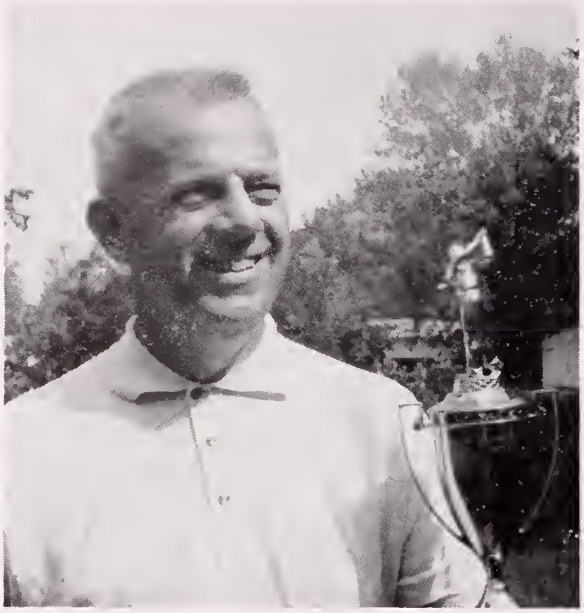


Dr. R. R. Brown of Romney exhibits the beautiful trophy he was awarded by winning his third Medical Golf Tournament title at The Greenbrier.

Dr. Robert R. Brown Retires Golf Trophy

Dr. Robert R. Brown of Romney was the top winner in the annual golf tournament, which was a recreational feature of the 99th Annual Meeting of the West Virginia State Medical Association.

Doctor Brown shot a 70 to win low gross honors for the third time and gain possession of the beautiful trophy sponsored by the Hospital and Physicians Supply Company of Charleston.

Runner-up to Doctor Brown was Dr. Joseph T. Mallamo of Fairmont, who shot a 71. The two physicians finished in the same order in 1965.

Other low gross scores included: Dr. J. P. Aliff of Charleston, 77; Dr. F. W. Mallamo of Fairmont, 78; and Dr. C. Stafford Clay of Huntington, 79.

The best low net scores included: Dr. Cary N. Moon, Jr., of Charlottesville, Virginia, 70; Dr. R. H. Fowlkes of Bluefield, 72; Dr. William E. Gilmore of Parkersburg, 72; Dr. George R. Callender, Jr., of Charleston, 72; and Dr. T. P. Mantz of Charleston, 72.

Dr. L. Dale Simmons of Clarksburg had the fewest putts with 26, and the winner of the blind bogey tournament was Dr. C. S. Harrison.

Dr. Joseph A. Smith of Dunbar was chairman of the tournament.

Centennial at The Greenbrier

The Council, at its pre-convention meeting, voted to hold the 100th Annual Meeting at The Greenbrier in 1967. The dates are August 24-26.

Since next year's meeting will mark the 100th anniversary of the Association, a special program is being planned.

ACP Invites Abstracts Of Papers

The American College of Physicians has called for abstracts of papers to be presented at its 48th annual session, which will be held in San Francisco, April 10-14.

The Committee on Scientific Program welcomes abstracts of work related to basic science, clinical investigation and clinical medicine.

Rules for submitting abstracts may be obtained by writing to Dr. Edward C. Rosenow, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

Camera Highlights

(See Pages 354-355)

(1) The final official function of the 99th Annual Meeting was the reception honoring officers of the Association, which was held in pleasant weather on the terrace of Chesapeake Hall. Here, the receiving line prepares to greet guests.

(2) Among the scores of doctors and others to congratulate Dr. Richard E. Flood on his elevation to the presidency was Dr. D. Sheffer Clark of Huntington (right).

(3) Dr. Charles E. Andrews of Morgantown studies a sheaf of proposals prior to the opening session of the House of Delegates.

(4) Dr. Edward R. Annis, Past President of the American Medical Association, captivated a large audience during an AMPAC-WESPAC address and an informal question-and-answer period that followed.

(5) Mr. Jack Canfield (left) and Mr. Paul Crabtree, assistants to Gov. Hulett C. Smith, make notes as the Governor speaks at the opening exercises of the meeting.

(6) Dr. Maynard P. Pride of Morgantown served as chairman of the Resolutions Committee.

(7) Dr. Robert W. Bess, Jr., of Piedmont prepares to take his seat for a session of the House of Delegates.

(8) Among several Past Presidents who attended a luncheon in their honor were Dr. L. J. Pace of Princeton (1962-63) and Dr. J. P. McMullen of Wellsburg (1955).

(9) Dr. Charles E. Staats of Charleston was among several members of the Kanawha Medical Society who attended the Annual Meeting.

(10) The photographer interrupted Dr. George R. Callender, Jr., of Charleston, Chairman of the Medical Economics Committee, as he put final touches on a report he submitted to the Executive Committee.

(11) Doctor Flood is shown with members of his family a few minutes before he took the oath as President of the Association. Seated: Miss Maura Jean Fahey, the doctor's niece; Mrs. Mildred Fahey and Miss Estelle Flood, his sisters; and Mrs. Ann E. Flood, mother. Standing: Mr. William T. Fahey, nephew; Doctor Flood; and Miss Mary Jane Fahey, niece.

(12) Medicare is no doubt the subject of this conversation between Dr. B. B. Richmond of Beckley (left), Medical Director of the Health Insurance Benefits Unit of the State Health Department, and Mr. Robert Campbell of Charleston, West Virginia Medicare Manager for Nationwide Insurance Company.

(13) A large crowd gathered in Governor's Hall to hear an address by Gov. Hulett C. Smith. In foreground are Dr. and Mrs. N. H. Dyer of Charleston.

Better Tuberculosis Reporting Urged By Doctor Dyer

State Health Director N. H. Dyer called for increased support from health personnel in combating tuberculosis in a recent issue of the "State of the State's Health." He said that last year there were 974 newly reported tuberculosis cases—an increase of 294 over 1964—and noted that health personnel seems to be losing ground rapidly.

Doctor Dyer said that one of the weakest points in the control of tuberculosis in West Virginia is the failure of physicians, hospitals, and other sources to report cases of tuberculosis when they are diagnosed as required by law.

He pointed out that of the 518 newly reported active cases of tuberculosis last year 20 were reported for the first time on death certificates. "This would indicate that either case-finding or reporting, or both, are not good," he said.

The health director explained that as the death certificates are sent to the Bureau of Tuberculosis Control, they are checked with the register, and if they have not already been reported, new cases are made of the deceased in order that contacts may be followed. He said that follow-up is delayed by the failure of the responsible party to report the disease at the time it was diagnosed.

"The control of tuberculosis is deterred in many of the counties by the failure of the local health officer to ask the prosecuting attorney to petition the court for an order to commit a person to a tuberculosis sanitarium when evidence of active tuberculosis is present," Doctor Dyer said.

He noted that when the case comes to court, it is essential that the health officer, or other physician testifying, have first hand knowledge of physical, x-ray, and sputum findings, in order to show without question the presence of tuberculosis in communicable state. He said that health department records should reveal this information.

At present, only Hopemont State Hospital is equipped to handle court order cases, but in the near future facilities may be available at Pinecrest Sanitarium in Beckley.

"While we are certain that the recommendations of the physicians in the diagnostic clinics have helped in getting the patients with active tuberculosis under adequate care and treatment, the last report of the 40 counties included in our project shows that only 58.1 per cent of these patients are receiving the required care," Doctor Dyer observed.

"Perhaps too many of our own health personnel have adopted the popular opinion that tuberculosis is of little importance today," Doctor Dyer said. "We must achieve widespread public understanding of the insidious nature of tuberculosis and increase our efforts to uncover cases and bring them to treatment. Until then, tuberculosis will continue to ravage the health of our people."

Doctor Dyer reported on the Hill-Burton Program in another issue of the "State of the State's Health" and said that he expects a backlog in requests for health facilities construction.

He noted that approximately 4,000 general hospital beds and 1,500 long-term care beds should be replaced or modernized. He said that the cost of modernizing and replacing obsolete general hospitals has been conservatively estimated at over $46 million.

Doctor Dyer said that the health department has requests from sponsors of proposed construction projects that represent a need for approximately $11 million in federal funds.

"On the basis of anticiated federal appropriations of $3.5 million annually, it is apparent that some of these pending projects must be delayed for as long as three years before an allocation of federal funds can be considered," Doctor Dyer said.

Dr. W. Gene Klingberg of Morgantown (center in left picture) enjoys a coffee break with two guest speakers, Dr. Doris A. Howell of Philadelphia and Dr. Robert I. Wise of Philadelphia. In picture at right, Gov. Hulett C. Smith (left) awaits the beginning of exercises marking the formal opening of the Annual Meeting, at which time he presented an address. With Governor Smith are the Rev. Douglas N. Shepherd of White Sulphur Springs, who gave the invocation; and Dr. Carl B. Hall of Charleston, Chairman of the Program Committee.

11th Postgraduate Institute Features Safety Panel

An Automobile Safety Panel, featuring controversial author-lawyer Ralph Nader, will be a feature of the 11th Annual Potomac-Shenandoah Valley Postgraduate Institute, which will be held in Martinsburg, October 28-30.

The program also will include more than a score of papers by noted authorities in the fields of basic science, obstetrics and gynecology, medicine and pediatrics, round table luncheons and social events. Scientific sessions will be held in the Apollo Theater, while scientific and industrial exhibits will be housed in the Shenandoah Hotel.

The three-day meeting is sponsored jointly by the West Virginia Chapter, American Academy of General Practice, and the Potomac-Shenandoah Valley Postgraduate Institute. The AAGP allows 20 hours of credit to those members who attend the sessions.

Friday Morning Session

The scientific session on Friday morning, October 28, will be devoted to papers on basic science and obstetrics and gynecology. Dr. Halvard Wanger, Executive Director of the Institute, said the program would include these speakers:

N. W. B. Craythorne, M. D., Chairman, Division of Anesthesiology, West Virginia University School of Medicine, Subject: "Arterial Hypotension: Basic Concepts Underlying, Differential Diagnosis and Management."

Jeffrey Chamberlain, M. D., Research Fellow in Obstetrics and Gynecology, George Washington University School of Medicine, Subject: "Drugs in Obstetrics."

D. Frank Kaltreider, M. D., Professor of Obstetrics and Gynecology, University of Maryland College of Medicine, Subject: "Preserving the Perineum."

Thaddeus L. Montgomery, M. D., Professor Emeritus of Obstetrics and Gynecology, Jefferson Medical College of Philadelphia, Subject: "Diagnosis and Management of Breast Lesions."

James G. Sites, M. D., Associate Professor of Obstetrics and Gynecology, George Washington University School of Medicine, Subject: "Septic Shock in Obstetrics and Gynecology."

Dr. Philip P. Steptoe, Associate Professor at Georgetown University, will serve as Moderator for a panel discussion concluding the morning session. A round table luncheon will follow.

Auto Safety Panel

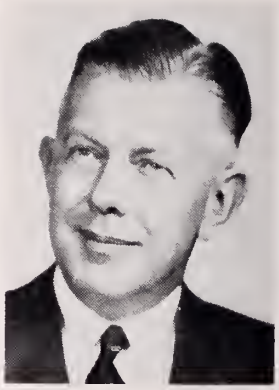
The panel discussion on Automobile Safety will be held on Friday afternoon with the following speakers:

Seymour Charles, M. D., Newark, New Jersey, President, Physicians for Automotive Safety, Subject: "The Physician's Responsibility in Automotive Safety."

Ralph Nader, Washington, D. C., Attorney and Author.

John C. Krantz, Jr., Ph.D., Professor Emeritus of Pharmacology, University of Maryland, Subject: "Drugs and Driving."

T. L. Montgomery, M. D.



John C. Krantz, Jr., Ph.D.

N. W. B. Craythorne, M. D., Chairman of the Division of Anesthesiology, West Virginia University School of Medicine, Subject: "Management of the Crushed Chest."

George H. Yeager, M. D., Professor of Surgery, University of Maryland Hospital, Baltimore, Subject: "Vascular Injuries."

Dr. Albert L. Chapman, former Assistant Surgeon General, will moderate a panel discussion at the end of the presentations.

Friday Night Dinner

Mr. Nader will be principal speaker at a dinner session Friday night. His topic will be announced later.

Saturday Morning Program

The program for Saturday morning is as follows:

Robert J. Johnson, M. D., Professor and Chairman, Department of Anatomy, Division of Graduate Medicine, University of Pennsylvania, Subject: "Anatomy of the External Examination of the Eye."

Joseph M. Lopresti, M. D., Clinical Associate Professor of Pediatrics, Georgetown University School of Medicine, Subject: "Aspirin Poisoning."

Walter E. Bundy, M. D., Associate Professor of Pediatrics, Medical College of Virginia, Subject: "Parents, Children, Problems."

Barbara Jones, M. D., Associate Professor of Pediatrics, West Virginia University School of Medicine, Subject: "Recent Advances in Leukemia of Childhood."

Joseph M. Lopresti, M. D., Chairman of Radiology, Children's Hospital, Washington, Subject: "Childhood Tuberculosis."

Hans Keitel, M. D., former Professor and Head of Pediatrics, Jefferson Medical College, Subject: "Premature Infant Feeding."

Doctor Jones will moderate the panel discussion at the end of the morning session. A round table luncheon will follow.

Saturday Afternoon

The Saturday afternoon program will be devoted to subjects in medicine. Speakers will be:

Thomas L. Auth, M. D., Department of Neurology, Georgetown University School of Medicine, Subject: "Neurological Aspects of Headache."

D. Frank Kaltreider, M. D.

Edmund B. Flink, M. D.

Edmund B. Flink, M. D., Chairman, Department of Medicine, West Virginia University School of Medicine, Subject: "Adrenal-Cortical Suppression and Methods of Avoiding."

Walter L. Henry, M. D., Chairman, Department of Medicine, Howard University School of Medicine, Subject: "Lesions of the Lower Extremities of the Diabetic."

Sol Katz, M. D. Chief, Medical Service, Veterans Administration Hospital, Washington, Subject: "The Lung in Skin Diseases."

Rex A. Pittinger, M. D., Associate Professor of Clinical Psychiatry, University of Pittsburgh School of Medicine, Subject: "Emotional Growth in Medical Practice."

Annual Banquet

A reception and the annual banquet will be held Saturday evening with Miss Nimal L. Wijeyaratne, an attache of the Ceylonese Embassy in Washington, serving as principal speaker. Her topic will be "Our Stake in the Economy of Southeast Asia."

The Annual Dance, featuring the music of the Russ Lang Orchestra of Washington, will follow the banquet.

Sunday Morning Program

Mr. Jim Comstock of Richwood, Editor of *The West Virginia Hillbilly,* will be the speaker at a luncheon following Sunday morning's scientific session. His topic will be "Trials and Tribulations of a Hillbilly Editor."

The scientific program for Sunday morning is as follows:

Robert J. Johnson, M. D., Professor and Chairman, Department of Anatomy, Division of Graduate Medicine, University of Pennsylvania, Subject: "Anatomical Explanation of Pupillary Changes."

John D. Young, Jr., M. D., Head, Division of Urological Surgery, University of Maryland School of Medicine, Subject: "Mechanisms of Anti-Diuresis and the Use of Osmotic Diuretics."

Raymond C. V. Robinson, M. D., Associate Professor of Dermatology, University of Maryland School of Medicine, Subject: "Cutaneous Manifestations of Systemic Diseases."

Abraham Genecin, M. D., Associate Professor of Medicine, Johns Hopkins University School of Medicine, Subject: "Problems in Digitalis Therapy."

Charles M. Caravati, M. D., Assistant Dean, Medical College of Virginia, Subject: "Diagnostic and Therapeutic Problems in Liver Disease."

Sunday Afternoon

The Sunday afternoon scientific program is as follows:

Alphonse C. Edmundowicz, M. D., Assistant Professor of Medicine, West Virginia University School of Medicine, Subject: "CPK—A New Diagnostic Aid in Myocardial Infarction."

Charles Van Buskirk, M. D., Chief, Division of Neurology, York Hospital, York, Pennsylvania, Subject: "Hallmarks of Extractanial Vascular Disease."

Registration Fee

The registration fee for the entire three-day meeting is $25, or $10 for a single day. Further information may be obtained by writing to Dr. Halvard Wanger, Executive Director, P. O. Box 175, Shepherdstown, West Virginia.

Neighboring State Presidents Attend Annual Meeting

The Presidents of three neighboring state medical associations and three Past Presidents were among guests at the 99th Annual Meeting of the West Virginia State Medical Association at The Greenbrier.

The Presidents who attended were Drs. Lawrence C. Meredith of Ohio, William B. West of Pennsylvania and Alexander McCausland of Virginia.

Past Presidents in attendance included Drs. George W. Petznick and Robert E. Tschantz, both of Ohio; and Archie Robert Cohen of Maryland.

Two AMA Past Presidents Appear in State

Two Past Presidents of the American Medical Association—Drs. Leonard W. Larson of Bismarck, North Dakota, and James Z. Appel of Lancaster, Pennsylvania—were scheduled for speaking engagements in West Virginia in October.

Doctor Larson, President of the American Cancer Society, was billed as principal speaker for the Annual Meeting of the Society's West Virginia Division, held on October 1 at Cacapon State Park.

A native of Minnesota, Doctor Larson is a pathologist. He has been a member of the Board of Directors of the Society for many years and was installed as President last October. He is the 31st President of the Cancer Society and was the 115th President of the AMA.

Doctor Appel, Immediate Past President of the AMA, will speak twice in Morgantown on October 6. He will speak to medical students and staff of the West Virginia University Medical Center at 4 P.M. in the Basic Sciences Building. At 6:30 P.M., he will be at Lakeview Country Club to address physicians from Harrison, Monongalia, Marion and Preston Counties.

His visit is sponsored by the WVU Chapter of the Student American Medical Association.

Doctor Appel, the 120th President of the AMA, served in that post until last June.

Mrs. Hu C. Myers Installed As Auxiliary President

Mrs. Hu C. Myers of Philippi was installed as President of the Woman's Auxiliary to the West Virginia State Medical Association during the Auxiliary's 42nd Annual Meeting at The Greenbrier in White Sulphur Springs, August 25-27.

Mrs. Hu C. Myers

Mrs. Myers succeeds Mrs. Wilson P. Smith of Huntington.

More than 200 physicians' wives attended the Auxiliary convention, which was held in conjunction with the 99th Annual Meeting of the West Virginia State Medical Association.

Mrs. Myers and other new officers were installed on Friday morning, August 26. Mrs. Asher Yaguda of Newark, New Jersey, President of the Woman's Auxiliary to the American Medical Association, presided at the installation ceremony.

Mrs. Yaguda also presented the keynote address on Thursday, August 25. Other speakers included Mr. J. E. Swan of Washington, D. C., Secretary of the National Electrical Contractors Association and brother of Mrs. Smith, the retiring President.

Other New Officers

The Auxiliary named Mrs. Rupert W. Powell of Fairmont as President Elect. She will succeed Mrs. Myers at next year's convention, which will be held at The Greenbrier, August 24-26.

Other officers for the coming year are as follows:

Mrs. Robert Tchou of Williamson, First Vice President (Western Region); Mrs. C. B. Buffington of Wheeling, Second Vice President (North Central Region); Mrs. Richard Starr of Beckley, Third Vice President (Southern Region); and Mrs. Robert W. Bess, Jr., of Westernport, Maryland, Fourth Vice President (Eastern Region).

Mrs. J. Dennis Kugel, of Charleston, Treasurer; Mrs. Joe N. Jarrett of Oak Hill, Recording Secretary; Mrs. William T. Lawson of Fairmont, Corresponding Secretary; and Mrs. D. E. Greeneltch of Wheeling, Parliamentarian.

Inaugural Address

In her inaugural address, Mrs. Myers mentioned some of the important advances in medicine of the past 100 years.

"All of these things have come about beginning with the horse-and-buggy doctor trudging along the muddy or dusty roads, to the doctor with the modern car driving mostly on paved roads, and in places on our super-highways," she noted. "This 100 years has brought us from the young man, who under the supervision of the local doctor 'read medicine' by day, and recited by night before going away to medical school . . . "

She reminded her listeners that when they married doctors, they also married the medical profession.

"When we married, each of us became a full-time partner in caring for the sick," she said. "We not only married a doctor, we married medicine."

She said medicine in the United States has progressed and flourished in a free society, but she warned that socialization threatens to stunt this growth.

"The year 1966 brings us to another era of Medicine in the United States," she observed. "We can no longer say we live in a free world of free men with medicine practiced by free physicians . . . The center of medicine has definitely been transferred to America, but in spite of this, physicians and the American people are being gradually forced into complete socialization of medicine."

She outlined the progress that the West Virginia Auxiliary has made in AMA-ERF and in rural health, mental health and other programs.

"We need to intensify our efforts in the recruitment of medical and para-medical students," she added. "We have been, and will continue to work toward influencing our medical students to return to our state, where they are desperately needed."

Committee Chairmen

The following appointments to committee chairmanships and other Auxiliary offices were announced:

Mrs. M. Bruce Martin of Huntington, AMA-ERF; Mrs. Joseph A. Smith of Dunbar, Archives and History; Mrs. William Thornhill, Jr., of Charleston, By-Laws and Handbook; Mrs. James H. Walker of Charleston, Community Service; Mrs. Pat A. Tuckwiller of Charleston, Convention; and Mrs. C. R. Davisson of Weston, Convention Co-Chairman.

Mrs. J. A. B. Holt of Charleston, Disaster Preparedness and Safety; Mrs. Richard K. Hanifan of Clarksburg, Editor, State News Bulletin; Mrs. Hugh Brown of Clarksburg, Circulation Manager, News Bulletin;

Mrs. Harry Beard of Huntington, Finance; and Mrs. Charles H. Hiles of Wheeling, Health Careers.

Mrs. Charles W. Merritt of Beckley, Legislation; Mrs. Clark K. Sleeth of Morgantown, Liaison to Woman's Auxiliary to the Student American Medical Association at West Virginia University; Mrs. Rupert W. Powell of Fairmont, Membership; Mrs. Buford W. McNeer of Hinton, Members-at-Large; and Mrs. John W. Hash of Charleston, Mental Health.

Mrs. Robert Janes of Fairmont, International Health Activities; Mrs. John D. Lindsay, Jr., of Fairmont, National Bulletin; Mrs. Myer Bogarad of Weirton, Necrology; Mrs. L. Dale Simmons of Clarksburg, Press and Publicity; Mrs. John J. Mahood of Bluefield, Program; Mrs. Lynwood D. Zinn of Clarksburg, Rural Health and Nutrition; and Mrs. Wilson P. Smith of Huntington, Southern Medical Councilor.

Executive and Advisory Boards

Mrs. Wilson P. Smith and Mrs. George A. Curry of Morgantown, both Past Presidents of the Auxiliary, will serve on the Board of Directors.

Dr. Seigle W. Parks of Charleston, Immediate Past President of the State Medical Association, will serve as Chairman of the Auxiliary's Medical Advisory Board.

Other members of the Advisory Board are Drs. D. E. Greeneltch of Wheeling, Wilson P. Smith of Huntington, George A. Curry of Morgantown and Hu C. Myers of Philippi.

The New President

Mrs. Myers, the new President, is the wife of Dr. Hu C. Myers, surgeon at the Myers Clinic and Broaddus Hospital in Philippi. They have one son, Robert L. Myers.

Mrs. Myers is a graduate of Broaddus Academy, Mountain State Business College and Alderson-Broaddus College, of which she has served as a Trustee for 15 years.

She has been Chairman of the Barbour County Unit of the American Cancer Society for 12 years and has served as President of The College Club, the Philippi Woman's Club and the Alderson-Broaddus Alumni Association.

For many years she has been active in the program of the Auxiliary at the local and state levels. She was President of the Barbour-Randolph-Tucker Auxiliary before its was disbanded several years ago.

She has served on various committees at the state level and was named President Elect of the State organization in August, 1965.

Auxiliary Ball

In addition to its business meetings, the Auxiliary also sponsored several social functions, including a Dixieland Ball, which was well attended by physicians, their wives and other guests.

Women Physicians Schedule Annual Meeting

The American Medical Women's Association will conduct its Annual Meeting in Washington, D. C., November 2-5.

The Association will install Dr. Elizabeth A. McGrew of Chicago as President, succeeding Dr. Margaret J. Schneider of Cincinnati.

National recognition for service to medicine will be given to an outstanding woman physician, who will receive the Elizabeth Blackwell Medal, named for the first United States woman medical graduate.

The Chicago Branch No. 2, Carroll Birch Award will be presented to the woman medical student who submits the best scientific paper.

A scientific session will be held on November 5. This will be a symposium on "Sexual Problems in Clinical Practice."

Additional information may be obtained by writing to Mrs. Gertrude F. Conroy, Executive Director, American Medical Women's Association, 1790 Broadway, New York, New York 10019.

New officers of the Woman's Auxiliary to the West Virginia State Medical Association are shown in left picture. Left to right: Mrs. J. Dennis Kugel of Charleston, Treasurer; Mrs. Rupert W. Powell of Fairmont, President Elect; Mrs. Joe N. Jarrett of Oak Hill, Recording Secretary; Mrs. Hu C. Myers of Philippi, President; and Mrs. Robert W. Bess, Jr., of Westernport, Maryland, and Mrs. Richard Starr of Beckley, Vice Presidents. In picture at right, Mrs. Asher Yaguda of Newark, New Jersey, President of the Woman's Auxiliary to the American Medical Association (center), chats with (left to right): Mrs. Myer Bogarad of Weirton; Mrs. Wilson P. Smith of Huntington, retiring President of the State Auxiliary; Mrs. Ross P. Daniel of Beckley; and Mrs. Pat A. Tuckwiller of Charleston.

Standing and Special Committees Named by Doctor Flood

Dr. Richard E. Flood of Weirton, President of the West Virginia State Medical Association, has appointed the standing and special committees which will function during his one-year term of office.

The committees are as follows:

Aging

Dominic A. Brancazio, Weirton, Chairman; Myer Bogarad, Weirton; E. Lyle Gage, Bluefield; Philip Johnson, Fairmont; Thomas H. Blake, St. Albans; and Thomas H. McGavack, Martinsburg.

Cancer

Hu C. Myers, Philippi, Chairman; Jack Basman, Charleston; F. Lloyd Blair, Parkersburg; W. Carroll Boggs, Wheeling; I. E. Buff, Charleston; L. Walter Fix, Martinsburg; Walter H. Gerwig, Clarksburg; David B. Gray, Charleston; George S. Kosar, Weirton; Theodore P. Mantz, Charleston; W. Hampton St. Clair, Jr., Bluefield; H. Jackson Teets, Weirton; Alvin L. Watne, Morgantown; Howard G. Weiler, Wheeling; and Chauncey B. Wright, Huntington.

Constitution and By-Laws

James S. Klumpp, Huntington, Chairman; J. C. Huffman, Buckhannon; Kenneth G. MacDonald, Charleston; L. J. Pace, Princeton; and Jack Leckie, Huntington.

Insurance

C. A. Hoffman, Huntington, Chairman; W. P. Bittinger, Oak Hill; Robert L. Chamberlain, Buckhannon; R. U. Drinkard, Wheeling; Upshur Higginbotham, Bluefield; Athey R. Lutz, Parkersburg; Kenneth G MacDonald, Charleston; Buford W. McNeer, Hinton; L. J. Pace, Princeton; and Andrew J. Weaver, Clarksburg.

Interprofessional Relations

J. C. Huffman, Buckhannon, Chairman.

Subcommittees

Medico-Legal: Paul H. Revercomb, Charleston, Chairman; George F. Evans, Clarksburg; W. L. Neal, Huntington; and Maynard P. Pride, Morgantown.

Medicine and Religion: Tracy N. Spencer, Jr., South Charleston, Chairman; Vernon L. Dyer, Petersburg; and William E. Gilmore, Parkersburg.

Medicine and Pharmacy: L. Dale Simmons, Clarksburg, Chairman; Andrew E. Amick, Lewisburg; and R. C. Cowan, Jr., Parkersburg.

Medical-Dental Liaison: Ray M. Bobbitt, Huntington, Chairman; George L. Armbrecht, Wheeling; and E. F. Heiskell, Jr., Morgantown.

Nurses Liaison: W. Fred Richmond, Beckley, Chairman; E. J. Van Liere, Morgantown; and Wilda S. Joseph, Wheeling.

Legislative

Frank J. Holroyd, Princeton, Chairman; John T Chambers, Charleston; E. M. Clubb, Jr., Weirton, Richard W. Corbitt, Parkersburg; George A. Curry Morgantown; Joseph L. Curry, Wheeling; Albert C. Esposito, Huntington; D. E. Greeneltch, Wheeling; N. B. Groves, Martinsburg; John W. Hash, Charleston; Logan W. Hovis, Parkersburg; J. C. Huffman, Buckhannon; Frank V. Langfitt, Clarksburg; Jack Leckie, Huntington; Charles L. Leonard, Elkins; Charles W. Merritt, Beckley; David W. Mullins, Logan; Maynard P. Pride, Morgantown; Thomas G. Reed, Charleston; Joseph D. Romino, Fairmont; William B. Rossman, Charleston; Page H. Seekford, Charleston; I. Ewen Taylor, Huntington; David B. Thornburgh, Parkersburg; A. J. Villani, Welch; Stephen D. Ward, Wheeling; Henry F. Warden, Jr., Bluefield; and Ward Wylie, Mullens.

Maternal and Perinatal Fetal Welfare

A. J. Villani, Welch, Chairman; Jack Basman, Charleston; Clarence H. Boso, Huntington; Thomas J. Conaty, Huntington; Robert D. Crooks, Parkersburg; Frederick H. Dobbs, Charleston; Thomas G. Folsom, Huntington; Emma Jane Freeman, Charleston; Nicholas W. Fugo, Morgantown; George L. Grubb, Charleston; C. S. Harrison, Clarksburg; William S. Herold, Charleston; Edwin J. Humphrey III, Huntington; W. Gene Klingberg, Morgantown; Charles W. Merritt, Beckley; Meryleen B. Smith, Peterstown; and Gates J. Wayburn, Huntington.

Medical Aspects of Sports

Richard W. Corbitt, Parkersburg, Chairman; J. Marshall Carter, Huntington; R. L. Chamberlain, Buckhannon; George F. Fordham, Mullens; William E. Gilmore, Parkersburg; Henry R. Glass, Jr., Charleston; J. W. Hesen, Jr., Morgantown; Joe N. Jarrett, Oak Hill; Gregory B. Krivchenia, Wheeling; Jack C. Morgan, Fairmont; George Naymick, Weirton; and W. H Rardin, Beckley.

Medical Economics

George R. Callender, Jr., Charleston, and Harry S. Weeks, Jr., Wheeling, Co-Chairmen.

Subcommittees

Federal Medical Activities: Charles M. Scott, Bluefield, Chairman; Walter H. Gerwig, Clarksburg; D. E. Greeneltch, Wheeling; Jack Leckie, Huntington; J. C. Pickett, Morgantown; and W. Fred Richmond, Beckley.

State Workmen's Compensation: Henry M. Hills, Jr., Charleston, Chairman; Thomas J. Holbrook, Huntington; John D. Lindsay, Jr., Fairmont; Kenneth G. MacDonald, Charleston; George Naymick, Weirton; J. C. Pickett, Morgantown; James T. Spencer, Charleston; and Worthy W. McKinney, Beckley.

Blue Cross - Blue Shield Third Party: Richard V. Lynch, Jr., Clarksburg, Chairman; Charles E. Andrews, Morgantown; Carter F. Cort, Fairmont; D. E. Greeneltch, Wheeling; Carl B. Hall, Charleston; C. A. Hoffman, Huntington; Ray M. Kessel, Logan; Athey R. Lutz, Parkersburg; and Charles M. Scott, Bluefield.

Public Welfare - Joint Conference Committee: Harry S. Weeks, Jr., Wheeling, Chairman; N. B. Groves, Martinsburg; Carl B. Hall, Charleston; Thomas J. Holbrook, Huntington; W. Gene Klingberg, Morgan-

town; Thomas P. Long, Man; W. Fred Richmond, Beckley; Charles M. Scott, Bluefield; Charles W. Thacker, Parkersburg; and J. D. H. Wilson, Clarksburg.

Special Studies: Kenneth G. MacDonald, Charleston, Chairman; A. B. Curry Ellison, Charleston; Carl B. Hall, Charleston; Henry M. Hills, Jr., Charleston; Thomas J. Holbrook, Huntington; and J. D. H. Wilson, Clarksburg.

Medical Education and Hospitals

Pat A. Tuckwiller, Charleston, Chairman; Arnold J. Brody, White Sulphur Springs; Del Roy R. Davis, Kingwood; William A. Ehrgott, Fairmont; William E. Gilmore, Parkersburg; Daniel Hamaty, Charleston; F. A. Hamilton, Jr., Martinsburg; Richard Hamilton, St. Marys; Upshur Higginbotham, Bluefield; C. A. Hoffman, Huntington; George M. Kellas, Wheeling; Jack Leckie, Huntington; David Z. Morgan, Morgantown; Arthur M. Phillips, Weirton; Thomas G. Reed, Charleston; Edwin M. Shepherd, Charleston; Clark K. Sleeth, Morgantown; Richard G. Starr, Beckley; Robert O. Strauch, Wheeling; A. C. Thompson, Elkins; William A. Thornhill, Jr., Charleston; and Andrew J. Weaver, Clarksburg.

Medical Scholarships

J. P. McMullen, Wellsburg, Chairman; Martha Jane Coyner, Harrisville; Thomas J. Holbrook, Huntington; Russel Kessel, Charleston; John Mark Moore, Wheeling; and Clark K. Sleeth, Morgantown.

Medical Emergencies and Civil Defense

John J. Mahood, Bluefield, Chairman; Harold D. Almond, Buckhannon; Dominic A. Brancazio, Weirton; Emil Capito, Weirton; Charles H. Hiles, Wheeling; John A. B. Holt, Charleston; Joseph T. Mallamo, Fairmont; Homer D. Martin, Dailey; James G. Ralston, Clarksburg; William S. Sadler, Barboursville; I. Ewen Taylor, Huntington; and E. Andrew Zepp, Martinsburg.

Mental Health

William B. Rossman, Charleston, Chairman; Mildred Mitchell-Bateman, Charleston; Randall Connolly, Vienna; Roy A. Edwards, Jr., Huntington; Ray S. Greco, Weirton; Thomas S. Knapp, Charleston; S. Elizabeth McFetridge, Shepherdstown; L. J. Pace, Princeton; Boylston D. Smith, Jr., Clarksburg; A. L. Wanner, Wheeling; Stephen D. Ward, Wheeling; William E. Wilkinson, Beckley; and A. C. Woofter, Parkersburg.

Military Medical Affairs

Russel Kessel, Charleston, Chairman; Bert Bradford, Charleston; Francis L. Coffey, Huntington; Walter H. Gerwig, Jr., Clarksburg; Charles M. Scott, Bluefield; Jack J. Stark, Belpre, Ohio; and Ward Wylie, Mullens.

Program

Ray S. Greco, Weirton, Chairman; Richard W. Corbitt, Parkersburg; Robert Greco, Morgantown; and Joseph D. Romino, Fairmont.

Public Service

Joseph L. Curry, Wheeling, Chairman; John M. Bobbitt, Huntington; William L. Cooke, Charleston; George A. Curry, Morgantown; C. R. Davisson, Weston; G. Thomas Evans, Fairmont; S. William Goff, Parkersburg; N. B. Groves, Martinsburg; Carl E. Johnson, Morgantown; E. Lee Jones, Wheeling; Jack Leckie, Huntington; L. J. Pace, Princeton; B. B. Richmond, Charleston; Page H. Seekford, Charleston; Jack J. Stark, Belpre, Ohio; and Stephen D. Ward, Wheeling.

Resolutions

Maynard P. Pride, Morgantown, Chairman; Albert C. Esposito, Huntington; Thomas J. Holbrook, Huntington; J. C. Huffman, Buckhannon; Charles L. Leonard, Elkins; Kenneth G. MacDonald, Charleston; and Seigle W. Parks, Charleston.

Rehabilitation

J. C. Pickett, Morgantown, Chairman; C. B. Buffington, Wheeling; Jean P. Cavender, Charleston; Kenneth L. Clark, Charleston; James A. Heckman, Huntington; Harold H. Kuhn, Charleston; Buford W. McNeer, Hinton; Ralph H. Nestmann, Charleston; Edwin M. Shepherd, Charleston; J. L. Thompson, Weirton; and Leonard E. Yurko, Weirton.

Rural Health

Martha Jane Coyner, Harrisville, Chairman; Harold D. Almond, Buckhannon; Andrew E. Amick, Lewisburg; J. C. Arnett, Rowlesburg; B. S. Brake, Clarksburg; Del Roy R. Davis, Kingwood; N. H. Dyer, Charleston; Vernon L. Dyer, Petersburg; Earl L. Fisher, Gassaway; O. M. Harper, Clendenin; J. C. Huffman, Buckhannon; Charles T. Lively, Weston; Ralph McGraw, Follansbee; Guy R. Post, Fairmont; Clark K. Sleeth, Morgantown; and Charles E. Staats, Charleston.

Syphilis

N. H. Dyer, Charleston, Chairman; Ross O. Bell, Wheeling; Paul L. McCuskey, Parkersburg; C. Y. Moser, Kingwood; Frank M. Peck, Huntington; David S. Pugh, Chester; Thomas L. Thomas, Wheeling; Lyle D. Vincent, Parkersburg; and James E. Wise, Follansbee.

Tuberculosis

William L. Cooke, Charleston, Chairman; Charles E. Andrews, Morgantown; Irwin M. Bogarad, Weirton; J. M. Brand, Chester; Oliver H. Brundage, Parkersburg; N. Allen Dyer, Bluefield; Hugh S. Edwards, Beckley; George F. Evans, Clarksburg; Ralph H. Nestmann, Charleston; M. A. Viggiano, New Martinsville; James H. Walker, Charleston; M. L. White, Jr., Huntington; and David H. Williams, Weirton.

SPECIAL COMMITTEES

AMA-ERF

J. Keith Pickens, Clarksburg, Chairman; Harry F. Cooper, Beckley; Richard W. Corbitt, Parkersburg; John E. Echols, Richwood; Robert J. Fleming, Morgantown; John W. Hash, Charleston; Joe N. Jarrett, Oak Hill; Jack Leckie, Huntington; Buford W. McNeer, Hinton; Jack C. Morgan, Fairmont; Earl S. Phillips, Wheeling; David S. Pugh, Weirton; and Donald R. Roberts, Elkins.

School Health

Peter A. Haley, Charleston, Chairman; J. M. Brand, Chester; Grover C. Hedrick, Jr., Beckley; Robert G. Janes, Fairmont; Thomas L. Thomas, Wheeling; Thomas G. Folsom, Huntington; A. M. Jones, Parkersburg; George W. Rose, Clarksburg; Paul C. Soulsby, St. Albans; Lyle D. Vincent, Parkersburg; and Eli J. Weller, Weirton.

WVU Liaison

Thomas L. Harris, Parkersburg, Chairman; Randall Connolly, Vienna; Albert C. Esposito, Huntington; George F. Evans, Clarksburg; John W. Hash, Charleston; John A. B. Holt, Charleston; J. C. Huffman, Buckhannon; Frank V. Langfitt, Clarksburg; Claude S. Lawson, Jr., Fairmont; Jack Leckie, Huntington; J. P. McMullen, Wellsburg; L. J. Pace, Princeton; Maynard P. Pride, Morgantown; W. Hampton St. Clair, Jr., Bluefield; I. Ewen Taylor, Huntington; and Frank J. Zsoldos, Mullens.

"Key Facts" Available

The Pharmaceutical Manufacturers Association has published a new edition of "Key Facts," which gives an assortment of figures and information about the prescription drug industry.

Copies may be obtained from the Association at 1155 Fifteenth Street, N. W., Washington, D. C. 20005.

Ohio Valley Hospital Plans Postgraduate Program

The Medical Education Committee of Ohio Valley General Hospital of Wheeling is planning a postgraduate medical education program, which will be held at Oglebay Park in Wheeling on November 13.

The following guest speakers will present papers:

Stanley O. Hoerr, M. D., Chairman, Division of Surgery, Cleveland Clinic.

Joseph M. Ryan, M. D., Professor of Medicine, Ohio State University.

John P. Caffey, M. D., Visiting Professor of Diagnostic Radiology and Pediatrics, University of Pittsburgh.

Walter H. Gerwig, Jr., M. D., Professor of Surgery, West Virginia University.

Donald L. Hutchinson, M. D., Professor and Chairman, Obstetrics and Gynecology, University of Pittsburgh.

William C. Sheldon, M. D., Department of Pediatric Cardiology and the Cardiac Laboratory, Cleveland Clinic.

Additional information may be obtained by writing to Dr. Robert S. Robbins, Publicity Chairman, Ohio Valley General Hospital, Wheeling, West Virginia 26003.

Dr. Ray S. Greco of Weirton (left), Chairman of the Program Committee for the 100th Annual Meeting next year, and Dr. Richard E. Flood, the President, display the special Centennial Emblem. Designed by a Weirton artist, Mr. Mitch Sagan, the emblem was approved by Council for official use during the Association's Centennial Year of 1967.

Pre-Convention Council Meeting At The Greenbrier, Aug. 24

The pre-convention meeting of the Council was held at The Greenbrier in White Sulphur Springs on Wednesday morning, August 24, 1966, with the Chairman, Dr. Albert C. Esposito of Huntington, presiding.

Doctor Esposito introduced a guest at the meeting, Dr. Charles L. Hudson of Cleveland, President of the American Medical Association.

It was reported that five resolutions had been submitted for consideration by the House of Delegates and would be introduced at the first session on Wednesday afternoon (the resolutions adopted by the House of Delegates are contained in the report of the Resolutions Committee which appears elsewhere in this issue of *The Journal*).

Dr. James S. Klumpp, Chairman of the Committee on Constitution and By-Laws, reported that four proposed amendments to the Constitution, offered during the 1965 Annual Meeting, would be acted upon at the first session on Wednesday afternoon.

Doctor Klumpp also reported that the Committee would offer several proposed amendments to the Constitution and By-Laws at the first session of the House. The Council approved the report and commended the Committee for its work during the past year (the amendments adopted by the House of Delegates appear elsewhere in this issue of *The Journal*).

Sponsorship of Workshop Approved

It was reported that the West Virginia Hospital Association was interested in co-sponsoring a "Workshop on Problems of Accreditation" during the Spring of 1967. The State Medical Association and the Hospital Association co-sponsored two workshops on Utilization Review and Implementation of the Medicare Law earlier in the year.

Following discussion, the Council agreed that the Association should co-sponsor a workshop on Accreditation in 1967.

Third-Party Programs

Dr. George R. Callender, Jr., Chairman of the Medical Economics Committee and Dr. Harry S. Weeks, Jr., Chairman of the Joint Conference Committee, presented detailed reports concerning the activities of their respective committees during the past year.

Doctor Callender reiterated the fact that all state and federal agencies had been notified of the position of the Association in regard to the billing of usual and customary charges for services rendered to beneficiaries of various programs. He stated that several bulletins had been mailed to members of the Association concerning recommended billing procedures for all third-party medical programs.

Doctor Weeks reported that he and other members of the Joint Conference Committee had met several times during the past few weeks with the Hon. L. L. Vincent, Commissioner of the State Welfare Department. He said every effort possible was being made to reach a mutually satisfactory agreement on billing policies in connection with the medical programs for welfare recipients. He stated that the Committees had received excellent cooperation from the Commissioner and members of his staff.

Report of Welfare Commissioner

Commissioner L. L. Vincent of the Welfare Department was invited to attend the Council meeting and was introduced by Doctor Esposito. The Commissioner stated at the outset that he was deeply appreciative of the fine cooperation he had received from members of the Joint Conference Committee and physicians throughout the State.

He discussed the problems which the Welfare Department had encountered in its role in the imple-

Dr. James S. Klumpp of Huntington (center in left picture) entertains two visiting sister state presidents at the Past Presidents' luncheon during the Annual Meeting. With Doctor Klumpp are Dr. Lawrence C. Meredith of Oberlin, Ohio, President of the Ohio State Medical Association (left); and Dr. William B. West of Oneida Heights, Pennsylvania, President of the Pennsylvania Medical Society. In picture at right, Dr. Edward R. Annis of Miami, Florida, (left) converses with Dr. George W. Petznick of Cleveland, a Past President of the Ohio State Medical Association. Doctor Annis, an honor guest at the meeting, addressed an AMPAC-WESPAC session.

mentation of the Medicare Law. There was lengthy discussion between Mr. Vincent and members of the Council concerning various phases of the welfare programs.

Auxiliary Advisory Board

It was reported that Mrs. Hu C. Myers of Philippi, President Elect of the Woman's Auxiliary to the State Medical Association, had submitted for approval of the Council the following list of physicians to serve as members of the Medical Advisory Board to the Auxiliary: Dr. Seigle W. Parks of Charleston, Chairman; and Drs. D. E. Greeneltch, Wheeling; Wilson P. Smith, Huntington; George A. Curry, Morgantown; and Hu C. Myers of Philippi.

The Council approved the appointment of the above named physicians to serve as members of the Advisory Board.

Election of Honorary Members

The Council elected Dr. Paul Levison of Beckley to honorary life membership in the State Medical Association.

Retiring Councilors

Doctor Parks reported that three physicians had completed four years of service as members of the Council and therefore would not be eligible for reelection: Drs. Richard W. Corbitt of Parkersburg, Charles L. Leonard of Elkins, and William B. Rossman of Charleston.

The Council went on record unanimously as expressing gratitude to Dr. Albert C. Esposito for his dedicated service as Chairman during the past year.

The Council meeting was attended by: Dr. Albert C. Esposito of Huntington, Chairman; Dr. Seigle W. Parks of Charleston, President; Dr. Richard E. Flood of Weirton, President Elect; Dr. Richard V. Lynch, Jr. of Clarksburg, Vice President; Dr. Kenneth G. MacDonald of Charleston, Treasurer; Dr. L. J. Pace of Princeton, Member of the Executive Committee; Drs. Maynard P. Pride of Morgantown; Andrew J. Weaver of Clarksburg; R. L. Chamberlain of Buckhannon; I. Ewen Taylor of Huntington; A. J. Villani of Welch; Buford W. McNeer of Hinton; Richard W. Corbitt of Parkersburg; William B. Rossman of Charleston; W. P. Bittinger of Oak Hill; and Mr. William H. Lively, Secretary ex officio.

The meeting also was attended by Dr. Frank J. Holroyd of Princeton and Dr. C. A. Hoffman of Huntington, AMA Delegates; Dr. Thomas G. Reed of Charleston, AMA Alternate; Dr. James S. Klumpp of Huntington, Parliamentarian; Dr. N. H. Dyer of Charleston, Director of the State Department of Health; Dr. George R. Callender, Jr. of Charleston, Chairman of the Committee on Medical Economics; Dr. Harry S. Weeks, Jr. of Wheeling, Chairman of the Joint Conference Committee; and Mr. David B. Weihaupt of Chicago, AMA Field Representative.

Heart Association Meeting In New York City

Registration forms may be obtained for the American Heart Association's 39th Scientific Sessions, to be held October 21-23 at the Americana Hotel in New York City.

Featured at the meeting will be six clinical sessions, consisting of panels, lectures, symposia and papers reporting clinical advances, and simultaneous programs on specialized subjects. The latter are designed as a forum for reporting on basic investigations in the cardiovascular field. Also included this year are six sessions on cardiovascular surgery.

As in the past, Cardiovascular Conferences—small and informal group discussions on a broad range of subjects—are scheduled for Saturday evening. Sunday's program includes an all-day showing of new cardiovascular films. Scientific and industrial exhibits will be on display throughout the three-day meeting.

Registration forms, which include applications for hotel reservations, are available from the West Virginia Heart Association, 759 Washington Street West, Charleston, West Virginia 25302.

Dr. L. Dale Simmons of Clarksburg (left in left picture) and Dr. R. L. Chamberlain of Buckhannon pause for the benefit of the photographer after registering for the 99th Annual Meeting. Picture at right shows members of the faculty of the West Virginia University School of Medicine who presented the scientific program on Saturday morning, August 27. Front row: Dr. Nicholas W. Fugo, Dr. Roland E. Schmidt and Dr. Clark K. Sleeth, Dean of the School. Back row: Dr. W. Gene Klingberg, Dr. Paul C. Davidson and Dr. Robert L. Vosburg.

Action Taken on Amendments To Constitution and By-Laws

The House of Delegates of the West Virginia State Medical Association adopted several amendments to the Constitution and By-Laws during the Annual Meeting at The Greenbrier.

Final action was taken on four proposed amendments to the Constitution which were offered initially at the 98th annual meeting in 1965. Delegates voted on the Constitutional amendments at the first session of the House of Delegates on Wednesday afternoon, August 24.

Of the four amendments to the Constitution before the House for consideration, one failed to receive the necessary two-thirds vote of the delegates present. This particular amendment would have made all past presidents life-time members of the House of Delegates. An amendment to the amendment which would have made past presidents members for a period of five years also failed to receive the necessary votes. Therefore, this section of the Constitution remains unchanged and past presidents will continue to be members of the House of Delegates for a period of 10 years following their tenure of office.

The following three amendments to the Constitution were adopted:

Amend Article VIII, Section 2, by deleting the entire section and inserting in lieu thereof the following: "The place and dates for each annual meeting of the Association shall be selected by the Council." (Prior to the adoption of the amendment, the place for the annual meeting was selected by the House of Delegates and the dates were selected by the Council).

Amend Article IX, Section 2, line 1, by inserting after the word, "Councilors," the words, "and the president." (Note: The reason for this amendment is the fact that the president is not elected but is installed into office from that of the president elect).

Amend Article IX, Section 4, line 5, by deleting the word, "president," and inserting in lieu thereof the words, "president elect." (Note: The reason for this amendment is that if the retiring president cannot be eligible for future election as president or vice president, neither should a past president be eligible for election as president elect).

Amendments to the By-Laws

The following amendments to the By-Laws were adopted by the House of Delegates at the second session on Saturday afternoon, August 27:

Amend Chapter II, Section 1, by deleting the words, "House of Delegates," and inserting in lieu thereof the word, "Council."

Amend Chapter IV, Section 2, by deleting the first sentence which reads, "Each component society shall be entitled to send to the House of Delegates each year one delegate who shall be the society's secretary, and one additional delegate for every twenty-five (25) members or fraction thereof," and insert in lieu thereof the following first sentence: "Each component society shall be entitled to send to the House of Delegates each year one delegate who shall be the society's secretary, and one additional delegate for every twenty (20) members or major fraction thereof."

Amend Chapter VII, Section 10, by deleting the entire Section and replacing with the following new Section 10: "The State of West Virginia shall be divided into fourteen Councilor Districts with the following geographical limits: District I—Hancock, Brooke, Ohio and Marshall Counties; District II—Marion, Taylor and Wetzel Counties; District III—Monongalia and Preston Counties; District IV—Morgan, Berkeley and Jefferson Counties; District V—Grant, Mineral, Hardy, Hampshire and Pendleton Counties; District VI—Barbour, Randolph, Tucker and Pocahontas Counties; District VII—Harrison, Tyler and Doddridge Counties; District VIII—Wood, Jackson, Pleasants, Ritchie, Wirt and Roane Counties; District IX—Lewis, Upshur, Gilmer, Calhoun, Braxton, Webster and Nicholas Counties; District X—Cabell, Mason, Wayne and Lincoln Counties; District XI—Kanawha, Putnam, Boone and Clay Counties; District XII—Raleigh, Fayette and Greenbrier Counties; District XIII—Mercer, Summers and Monroe Counties; and District XIV—McDowell, Wyoming, Mingo and Logan Counties.

Amend Chapter VII, Section 11, by deleting entire Section and substitute therefor the following new Section 11: "The tenure in office of all incumbent Councilors shall end with the adoption of this amendment and its conformity with the provisions in the Constitution. Thereafter, during the annual meeting at which such enabling amendments are adopted, there shall be elected one Councilor from each even-numbered Councilor District to serve for one year, and one Councilor from each odd-numbered District to serve a term of two years. Thereafter, Councilors from even-numbered Districts shall be elected for a two-year term in even-numbered years, and Councilors from odd-numbered Districts in odd-numbered years for a term of two years.

Amend Chapter VIII, Section 5, Sub-Section (o), by deleting the first sentence and substitute therefor the following sentence: "The Committee on Nominations shall consist of six Councilors, elected prior to the first session at each annual meeting by Council, with the junior Councilor-at-Large serving as Chairman."

Proposed Constitutional Amendments

Three proposed amendments to the Constitution, which were offered at the first session of the House of Delegates by Dr. James S. Klumpp of Huntington, Chairman of the Committee on Constitution and By-Laws, will be submitted to the House of Delegates for final action at the 100th Annual Meeting at The Greenbrier, August 24-26, 1967.

The proposed amendments are as follows:

(1) Amend Article IX, Section 1, line 3, by deleting the word, "twelve," and substituting therefor the word, "fourteen."

(2) Amend Article IX, Section 2, line 4, by deleting the words, "each year," and substituting therefor the words, "every second year as shall be provided for in the By-Laws for reapportionment of Councilor Districts."

(3) Amend Article IX, Section 2, paragraph 3, line 4, by adding ", except as provided in the By-Laws pertinent to reapportionment of Councilor Districts."

Congress on Socio-Economics Of Health Care

The American Medical Association's Council on Medical Service and Division of Socio-Economic Activities will sponsor the First National Congress on Socio-Economics of Health Care early next year.

The sessions will be held at the Palmer House in Chicago, January 22-23. Authorities in the fields of medicine, health care administration, social science, education, community planning and other disciplines will participate.

They will report on new issues, developments and techniques in the organization, delivery and financing of health care services.

Additional information may be obtained by writing to Dr. H. W. Doan, Secretary, Council on Medical Service, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

National Medicolegal Symposium

The 1967 Medicolegal Symposium sponsored by the American Bar Association and the American Medical Association will be held in Miami Beach, Florida, March 9-11, 1967.

There will be a $30 registration fee. Additional information may be obtained by writing to 1967 Medicolegal Symposium, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Doctor Lynch New President Of TB Association

Dr. Richard V. Lynch, Jr., of Clarksburg, President Elect of the West Virginia State Medical Association, was elected President of the West Virginia Tuberculosis and Health Association during that organization's meeting in Charleston in September.

Richard V. Lynch, Jr., M. D.

Other new officers are: the Rev. Winton R. Houck of Charleston, Treasurer; Mr. Estes Moore of Fairmont, Vice President; and Mrs. Spencer Creel of Parkersburg, Secretary.

Dr. George F. Fordham of Mullens was re-elected President of the West Virginia Thoracic Association, the scientific arm of the Tuberculosis and Health Association.

3,000 Physicians Are Expected For AAGP Meeting

The first fall Scientific Assembly of the American Academy of General Practice will be held in Boston, October 10-13.

Dr. Seigle W. Parks of Charleston, Immediate Past President of the West Virginia State Medical Association, served as Chairman of the Scientific Assembly Committee which planned the scientific program.

Seigle W. Parks, M. D.

Doctor Parks will serve as moderator of a Symposium on Cardiovascular Disease, which will follow the noon recess on Thursday, October 13.

About 3,000 physicians are expected to attend the four-day program, which will feature a panel discussion of the problems of adolescence, discussions of such topics as stroke, obstetrics, mental retardation and heart disease, and two half-days of bedside refresher courses at 14 hospitals.

Doctor Parks said that more than 1,100 doctors will be accommodated in the clinical refresher courses. There will be almost 60 courses offered each day on topics ranging from treatment of cardiac arrest to leukemia and office gynecology. The courses will be conducted for groups of five to ten participants.

The AAGP has approved the program for a total of 19 hours of credit for its members, who must complete 150 hours of approved credit every three years.

The scientific program will follow the annual meeting of the AAGP's Congress of Delegates, October 8-10.

The Delegates' Dinner will be held Monday night, October 10. The President's Reception Wednesday night will honor the retiring President, Dr. Amos N. Johnson of Garland, North Carolina. The reception will follow inauguration of the new President, Dr. Carroll L. Witten of Louisville, Kentucky.

West Virginia's AAGP delegates are Doctor Parks and Dr. Carl B. Hall of Charleston.

Association for Mental Health Has 12th Annual Meeting

The West Virginia Association for Mental Health, Inc., held its 12th Annual Meeting in Parkersburg, September 30-October 1.

Dr. T. Glenn Roberts, President of the Association, presided at the sessions.

A feature of the program was a panel discussion of "Our State Hospitals' Progress and Needs." Participants included Dr. Kenneth Byrne, Superintendent of Lakin State Hospital; Dr. Cornelia Wilbur, Superintendent of Weston State Hospital; and Dr. Gaston deLemos, Superintendent of Huntington State Hospital.

100TH ANNUAL MEETING

of the

West Virginia State Medical Association

The Greenbrier

AUGUST 24 - 26, 1967

CENTENNIAL YEAR 1867-1967

Sections and Affiliated Societies Elect Officers for 1966-67

Meetings of sections and affiliated societies and associations of the West Virginia State Medical Association were held during the 99th Annual Meeting at The Greenbrier, August 25-27.

Officers for the coming year are:

Sections

Orthopedic Surgery: Thomas F. Scott, Huntington, President; A. A. Abplanalp, Charleston, Vice President; and John P. Griffith, Wheeling, Secretary-Treasurer.

W. Va. Radiological Society: W. Alva Deardorff, Charleston, President; Ilona D. Scott, Lewisburg, Vice President; and George G. Green, Morgantown, Secretary-Treasurer.

W. Va. Acad. of Oph. and Otol.: Worthy W. McKinney, Beckley, President; William C. Morgan, Charleston, President Elect; and J. Elliott Blaydes. Jr., Bluefield, Secretary-Treasurer.

Neurology, Neurosurgery and Psychiatry: David M. Wayne, Bluefield, President; Thomas S. Knapp, Charleston, President Elect; and Mildred M. Bateman, Charleston, Secretary-Treasurer.

Surgery: Ray E. Burger, Welch, President.

Internal Medicine: George A. Curry, Morgantown, President; and E. L. Crumpacker, White Sulphur Springs, Secretary-Treasurer.

Urology: D. Franklin Milam, Morgantown, President; Harold N. Kagan, Huntington, Vice President; and Michel A. Glucksman, Elkins, Secretary-Treasurer.

W. Va. Pediatric Society: Emma Jane Freeman, Charleston, President; Forest A. Cornwell, Beckley, Vice President; and Heinz J. Wittig, Morgantown, Secretary-Treasurer.

The West Virginia Association of Pathologists canceled its meeting at The Greenbrier but will meet later this year.

Societies

W. Va. State Society of Allergy: Robert S. Mutch, Fairmont, President; W. L. Neal, Huntington, Vice President; and Merle S. Scherr, Charleston, Secretary-Treasurer.

W. Va. Society of Anesthesiologists; Norman W. B. Craythorne, Morgantown, President; Logan W. Hovis, Parkersburg, Vice President; and Allen E. Yeakel, Morgantown, Secretary-Treasurer.

W. Va. Ob. and Gyn. Society: Daniel A. Mairs, Charleston, President; Robert Greco, Morgantown, Vice President; and A. J. Villani, Welch, Secretary-Treasurer.

Arthritis Program in Pennsylvania

The Pennsylvania Arthritis Foundation will sponsor a program on "Arthritis in Practice" at the Penn Sheraton Hotel in Pittsburgh, October 10-12.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1966

Oct. 1-5—Am. Soc. of Anesthesiologists, Philadelphia.
Oct. 6—Rural Health Conf., Jackson's Mill.
Oct. 7-8—AMA Cong. on Medical Quackery, Chicago.
Oct. 10-13—AAGP, Boston.
Oct. 10-14—ACS, San Francisco.
Oct. 11-14—Pennsylvania Medical, Pittsburgh.
Oct. 13-15—Assn. of Am. Phy. & Surg., Disneyland, Calif.
Oct. 15—Cabell County Symposium, Huntington.
Oct. 15-16—Am. Assn. of Oph., Chicago.
Oct. 16-21—Am. Acad. of Oph. & Otol., Chicago.
Oct. 21-25—Am. Heart Assn., New York.
Oct. 22-27—Am. Acad. of Pediatrics, Chicago.
Oct. 23-26—Am. Col. of Gastroenterology, Philadelphia.
Oct. 28-30—Potomac-Shenandoah Valley PG Inst., Martinsburg.
Oct. 31-Nov. 4—Am. Assn. of Public Health Physicians, San Francisco.
Nov. 6-9—Med. Soc. of Virginia, Williamsburg.
Nov. 14-17—Southern Med. Assn., Washington.
Nov. 15-20—Am. Medical Womens Assn., Washington.
Nov. 26-27—Am. Col. of Chest Physicians, Las Vegas.
Nov. 27-30—AMA Clinical Convention, Las Vegas.
Nov. 27—Nat. Conf. on the Med. Aspects of Sports, Las Vegas.
Nov. 29-Dec. 1—Am. Acad. for Cerebral Palsy, Biloxi-Gulfport, Miss.
Dec. 2-3—Am. Rheumatism Assn., Cincinnati.
Dec. 3-6—Am. Acad. for Cerebral Palsy, New Orleans.
Dec. 3-8—Am. Acad. of Dermatology, Bal Harbour, Fla.
Dec. 4-7—Am. Soc. of Hematology, New Orleans.
Dec. 6-8—Southern Surgical Assn., Boca Raton, Fla.

1967

Jan. 14-19—Am. Acad. of Orthopaedic Surgeons, San Francisco.
Jan. 20-21—ACP Regional Meeting, Morgantown.
Jan. 31-Feb. 4—Am. Col. of Radiology, Chicago.
Feb. 14-19—Am. Col. of Cardiology, Washington.
Feb. 18-22—Am. Acad. of Allergy, Palm Springs Calif.
Feb. 28—Nat. Multiple Sclerosis Soc., New York.
March 9-11—AMA-ABA National Medicolegal Symposium, Miami Beach.
March 10-11—AMA Conf. on Rural Health, Charlotte, N. C.
March 19-24—Southeastern Surgical Cong., Bal Harbour, Fla.
March 19-24—Am. Col. of Allergists, New Orleans.
April 3-5—Am. Acad. of Ped., San Francisco.
April 7-9—Am. Soc. of Int. Med., San Francisco.
April 10-14—Am. Col. of Physicians, San Francisco.
April 16-20—Am. Col. of Ob. & Gyn., Philadelphia.
April 17-19—Am. Assn. for Thoracic Surgery, New York.
April 23-26—W. Va. Acad. of Oph. and Otol., White Sulphur Springs.
April 19-21—Maryland Medical, Baltimore.
April 27-28—Am. Ped Soc., Atlantic City.
April 30-May 2—W. Va. Chapter, AAGP, Huntington.
April 30-May 5—Int Col. of Surgeons, Bal Harbour, Fla.
May 6—Am. Col. of Psychiatrists, Philadelphia.
May 29-June 1—Am. Urol. Assn., New York.
Aug. 24-26—100th Annual Meeting, W. Va. State Medical Assn., The Greenbrier, White Sulphur Springs.

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*Schiller, I. W., and Lowell, F. C.: New England J. Med. 261:478, 1959.

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Phenobarbital (¼ gr.) ..... 16.2 mg.
(Warning: may be habit forming)
Aspirin (2½ gr.) .....162.0 mg.
Phenacetin (3 gr.) .....194.0 mg.
Hyoscyamine sulfate.....0.031 mg.
Codeine phosphate.....¼ gr. (No. 2), ½ gr. (No. 3), 1 gr. (No. 4)
(Warning: may be habit forming)

Contraindications: Hypersensitivity to any ingredient.

Precautions: As with all phenacetin-containing products, avoid excessive or prolonged use.

Side Effects: Side effects are uncommon—nausea, constipation, and drowsiness have been reported.

A·H·ROBINS

A. H. ROBINS CO., INC., Richmond, Va. 23220

This is a logical Blood Pressure Regulator

BECAUSE IT ENHANCES THE BODY'S OWN MECHANISMS FOR REDUCING BLOOD PRESSURE

In mild to moderate hypertension:

Salutensin enhances the body's own mechanisms for lowering blood pressure. The veratrum component of Salutensin acts on the carotid sinus and myocardial receptors, initiating "...a reflex fall in blood pressure through a generalized vasodilation and fall in heart rate."[2] To achieve this reflex modification of hypertension, Salutensin utilizes protoveratrine A.
In addition, to facilitate and maintain blood pressure reduction, Salutensin incorporates reserpine and a highly effective thiazide.
In general, side effects have been reported infrequently but may include those listed in the therapeutic summary.

Simple dosage—low-cost therapy: Many patients on Salutensin respond to 1 tablet *b.i.d.* Long-term economy is assured, since dosage can frequently be lowered after initial control is established.

Available: Prescription-size bottles of 60 tablets.

References: 1. Editorial: JAMA *191*:592 (Feb. 15) 1965. 2. Meilman, E., in Moyer, J.H.: Hypertension, Philadelphia, W.B. Saunders Company, 1959, p. 395.

BRISTOL THERAPEUTIC SUMMARY
For complete information consult Official Package Circular.
Indications: Essential hypertension.
Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs.
Contraindications: Salutensin is contraindicated in severe depression.
Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss, which may cause digitalis intoxication, responds to potassium-rich foods, potassium chloride or, if necessary, stopping therapy. Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy two weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution with patients with peptic ulcers or renal insufficiency (if severe, Salutensin is contraindicated).
Side Effects: Hydroflumethiazide: Purpura plus or minus thrombocytopenia, hyperuricemia, leukopenia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)
Usual Dose: 1 tablet *b.i.d.*

BRISTOL
BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York

Salutensin®

Each tablet contains: protoveratrine A, 0.2 mg.; hydroflumethiazide, 50 mg.; reserpine, 0.125 mg.

WVU Medical Center
—News—

SEVERAL physicians have been appointed to the house staff of West Virginia University Hospital for training as interns and residents.

The 15 interns and 14 residents began their training in July. The new residents and their specialties are as follows:

Medicine: Dr. Young Jo Song, Japan; Dr. Raymond B. Weiss, Washington, D. C., and Dr. William C. Stewart, Charleston.

Orthopedic Surgery: Dr. Frederick C. Corrado, Uniontown, Pennsylvania; Dr. Siew Kee Koay, Malaysia; and Dr. Garret H. Conner, New Brunswick, New Jersey.

Otolaryngology: Dr. A. P. Avery, Lexington, Kentucky; Dr. T. F. Hall, Fairmont; and Dr. Fred D. Owens, Georgetown, Kentucky.

General Surgery: Dr. William A. Bernie, Dayton, Ohio; Dr. J. G. Johnson, Little Fork, Minnesota and Dr. Y-Shou Su, Formosa.

Neurosurgery: Dr. Augusto Fojas Figueroa, Philippine Islands.

Urology: Dr. Arnold F. Cruspe, Philippine Islands.

The new interns are as follows:

Drs. Patsy B. Cipolloni, Masontown; James A. Daniel, Minneapolis; E. Louise E. Eschenmann, Clarksburg; Patricia McKay Gregg, Morgantown; Stanleigh E. Jenkins, Blackstone, Virginia; Douglas V. Jewson, Minneapolis; annd Lowell E. Johnson, Bovay, Minnesota.

Drs. Charles L. Langeberg, Austin, Minnesota; David B. Plimpton, Wayzata, Minnesota; David Sutherland, St. Paul, Minnesota; Alexander Wanger, Shepherdstown; Arthur N. Ward, Fairmont; Theodore J. Buselmeier, Buffalo, Minnesota; Robert S. Salisburg, Fairmont; and Warren R. Pistey, Bridgeport, Connecticut.

Scholarship Recipient

Joseph D. Ruffner, Jr., of Morgantown, has been designated the first recipient of the New York Life Insurance Company medical scholarship at the School of Medicine. He began his studies on September 5.

The University is one of 11 schools in the country selected by New York Life for its Medical Student Scholarship Program. The program covers tuition, books, housing, board and equipment for the four years of study. It is subject to renewal annually.

Mr. Ruffner, son of Mr. and Mrs. Joseph D. Ruffner, Sr., is a graduate of Morgantown High school and received his B.A. degree from WVU in 1965. He is married to the former Elizabeth Burrows of Morgantown.

• **Compiled from material furnished by Arthur V. Ciervo, Director, Medical Center News and Information Services, Morgantown, West Virginia.**

Other Scholarships

The School of Medicine recently announced 27 other scholarship awards.

Fred A. Brindle, a junior medical student from Martinsburg, was awarded the $1,000 Pfizer Laboratories scholarship for the second straight year. The Harris Scholarship of $350 went to Richard H. Sibley, a Nitro senior, also for the second year. A medical scholarship of $400 from the Claude Worthington Benedum Foundation was awarded to Fred W. Holt, a junior from Charleston.

Board of Governors' graduate scholarships, which cover tuition, were awarded to 24 students. They are:

First year: David P. Lee, Nitro; Linda Ann Long, Morgantown; Susan Thayer, South Charleston; Roger L. McCauley, Belington; John E. Van Guilder, Fairmont; and David K. Walker, St. Albans.

Second year: Robert J. Fagioletti, Grindstone; Richard J. O'Brien, Jr., Wheeling; James R. Castle, St. Albans; Robert B. Gainer, Clarksburg; Roger P. Nichols, St. Albans; and Michael J. McGinnis, Pittsburgh.

Third year: Timothy K. Bowers, Martinsburg; James W. Campbell, Weirton; W. Albert Dow, Clairton, Pennsylvania; Frederick C. Newton, Hinton; Marion B. Tallent, Jr., Martinsburg; and Ronald L. Wilkinson, Charleston.

Fourth year: James C. Cosmides, Wheeling; James F. Grow, Jr., Cuyahoga Falls, Ohio; Larry O. Harper, Morgantown; Joseph R. Metz, Erie, Pennsylvania; David A. Santrock, Dunbar, and Nancy Spitznogle Sibert, Follansbee.

Faculty Appointment

Dr. David S. Jones, a native of Holliday, Missouri, has joined the School of Medicine as Professor of Anatomy.

Doctor Jones, who has taught for 29 years, received a B.S. degree from Westminster College in Fulton, Missouri; and a master's degree from St. Louis University. In 1937, he earned his doctorate in anatomy at the University of Minnesota, and in 1945, his M.D. degree from Loyola University in Chicago.

SAINT ALBANS
PSYCHIATRIC HOSPITAL

Radford, Virginia

James P. King, M. D., Director

William D. Keck, M. D.
Clinical Director
James K. Morrow, M. D.
Morgan E. Scott, M. D.

Clinical Psychology:
Thomas C. Camp, Ph. D.
Card McGraw, Ph. D.
David F. Strahley, Ph. D.

Edward E. Cale, M. D.
Malcolm G. MacAulay, M. D.
Don L. Weston, M. D.
J. William Giesen, M. D.

Don Phillips, Administrator
R. Lindsay Shuff, M. H. A.
Asst. Administrator

AFFILIATED CLINICS

Bluefield Mental Health Center
525 Bland St., Bluefield, W. Va.
David M. Wayne, M. D.

Beckley Mental Health Center
109 E. Main Street, Beckley, W. Va.
W. E. Wilkinson, M. D.

Charleston Mental Health Center
1206 Quarrier St., Charleston, W. Va.
E. E. Gimenez, M. D.

Mental Health Clinic
Professional Building, Wise, Va.
Pierce D. Nelson, M. D.

The Month in Washington

• **From the Washington Office of the American Medical Association.**

THE Advisory Committee on Obstetrics and Gynecology to the Food and Drug Administration reported that in a nine-month study it could find "no adequate scientific data" that birth control pills are "unsafe for human use."

But the committee said that there are "possible theoretic risks" in the use of oral contraceptives. For this reason, the committee recommended further, extensive tests to learn more about possible side-effects and to improve surveillance of the drugs.

The FDA accepted this proposal and other committee recommendations, including discontinuance of time limitations on use of oral contraceptives.

FDA Commissioner Dr. James Goddard said the agency would like to start studies on up to 50,000 women next year and eventually on as many as 500,000 women. The biggest drug studies thus far have involved ony 20,000 or 30,000 women.

"The committee finds no adequate scientific data, at this time, proving these compounds unsafe for human use. It has nevertheless taken full cognizance of certain very infrequent but serious side-effects and of possible theoretic risks suggested by animal experimental data and by some of the metabolic changes in human beings," the committee concluded.

"In the final analysis, each physician must evaluate the advantages and the risks of this method of contraception in comparison with other available methods or with no contraception at all. He can do this wisely only when there is presented to him dispassionate scientific knowledge of the available data."

The FDA said it would lift shortly its recommended limits on use of the pill. The agency has required that manufacturers state on their labels and advise physicians that the oral contraceptives should be used by individuals for no more than four years because of concern about the unknown long-term effect of the medications. FDA officials and the advisory committee agreed that there isn't any sound scientific rationale for the restriction, because of the current lack of data that would indicate that the pills are dangerous.

Other steps that FDA officials said would be taken as a result of the report include imposition of uniform labeling requirements on all types of oral contraceptives, elimination of product-by-product variations that have confused physicians and allowed companies to make different promotional claims, and restrictions of the use of the products for some medical purposes, such as prevention of abortion and treating lack of menstruation or painful menstruation, as well as conception control.

"The oral contraceptives present society with problems unique in the history of human therapeutics," the committee said. "Never will so many people have taken such potent drugs voluntarily over such a protracted period for an objective other than for the control of disease. These compounds, furthermore, furnish almost completely effective contraception, for the first time available to the medically indigent, as well as the socially privileged. These factors render the usual standards for safety and surveillance inadequate. Their necessary revision must be carefully planned and tested, lest the health and social benefits derived from these contraceptives be seriously reduced. Probably no substance, even common table salt, and certainly no effective drug can be taken over a long period of time without some risk, albeit minimal. There will always be a sensitive individual who may react adversely to any drug, and the oral contraceptives cannot be made free of such adverse potentials, which must be recognized and kept under continual surveillance. The potential dangers must also be carefully balanced against the health and social benefits that effective contraceptives provide for the individual woman and society."

Generic Name Legislation

The American Medical Association opposed legislation that would make prescribing drugs by generic name mandatory under the federal program of medical care for dependents of military personnel.

The AMA expressed its opposition in a letter to a joint House-Senate committee that was considering such legislation. The letter said:

"The generic name refers to the active chemical ingredient of the drug and not to the finished product which is supplied to the patient. In order that it may be dispensed, the tradename manufacturer, by way of a specific formulation, processes the drug to its final form. For example, included in a manufacturer's preparation of a tablet form of a drug may be a number of variables such as the crystalline size, the nature of the excipients, the coloring agents and flavors, the tableting pressures, coating films, and the orientation within the tablet."

SQUIBB NOTES ON THERAPY

Breast-feeding and the "modern mother"

Despite a mild resurgence of interest in the importance of breast-feeding a few years ago, many women today do not choose to nurse their young. This is for a variety of reasons—social, economic, cultural and sometimes medical. In such cases the physician's task is to find the most suitable means of preventing lactation and easing the pain of breast engorgement.

The means of therapy

The value of hormone therapy for this indication is of course well established. Both androgen and estrogen are known to inhibit the production and secretion of the lactogenic hormone by the anterior pituitary. As estrogen levels decline sharply at parturition, lactogenesis is established. When androgen and estrogen are administered to the patient before the release of the lactogenic hormone lactation and breast engorgement are usually prevented.

The time of therapy

The time of administration of this combined medication is crucial; it must be given early enough to suppress the pituitary prolactin and last long enough to permit physiologic readjustment during the puerperium. Excellent results are most often seen when therapy is administered before the onset of the second stage of labor.

However, factors other than effectiveness must also be considered. The agent selected should not interfere in any way with parturition, subsequent uterine involution and the restoration of normal ovarian cyclic function. Furthermore, it should not cause rebound breast engorgement or other manifestations of hormonal imbalance.

A balanced formulation

Providing single-dose therapy for the prevention of lactation and breast engorgement, Deladumone OB is a potent androgen-estrogen combination with a prolonged action. The optimal balance of androgenic and estrogenic hormones achieved in this preparation minimizes the disadvantages inherent in single hormone therapy, such as rebound breast engorgement. Involution of the uterus and resumption of menstrual cycles are not affected.

As reported in a recent published study (Roser, D. M.: Obstet. & Gynec. *27*:73, 1966), Deladumone OB provided good suppression of breast engorgement in 95.3% and suppression of lactation in 81.1% of 86 obstetrical patients. These results are in general agreement with those of many earlier investigations; in several studies this injectable androgen-estrogen combination proved to be superior to oral medication.

Dosage:

As a single injection of 2 cc. before the onset of the second stage of labor.

Contraindications:

Established or suspected mammary cancer or genital malignancy.

Precautions and Side Effects:

Certain patients may be unusually responsive to either estrogenic or androgenic therapy. In such individuals virilization, uterine bleeding or mastodynia may occur.

Supply:

Deladumone OB, providing 180 mg. testosterone enanthate and 8 mg. estradiol valerate per cc., is available in 2 cc. Unimatic® disposable syringes and in 2 cc. vials. Both preparations are dissolved in sesame oil, with 2% benzyl alcohol as a preservative. *Before use, consult product literature for full prescribing information.*

Deladumone® OB

Squibb Testosterone Enanthate (180 mg./cc.) and Estradiol Valerate (8 mg./cc.)

Single-dose injection for lactation inhibition

SQUIBB *'The Priceless Ingredient' of every product is the honor and integrity of its maker.*

Annual Reports *

Committee on Presidential Address

The President has elected to present his annual address in the form of a report on his hopes and accomplishments to the membership of our Association. His selection of the problems involved in Medicare, state and county society relations, expansion of state medical organization, the ever-continued shortage of physicians, and our responsibilities in the recruitment and training of paramedical personnel, is most certainly a concise statement of our major interests and responsibilities, not only current, but extending well into future years.

The President has very aptly termed this advent of Medicare the major social experiment of our times, and has reminded his constituents, that, although we have struggled for a generation to forestall any such socialistic venture, its enactment into law must impress upon the heart, mind and conscience of every man of medicine the fact that he, the individual physician, has incurred a three-fold responsibility which became effective with the birth of this unwanted, politically inspired sibling into the Great Society. As physicians and citizens we must employ our talents, experience and actions in three ways—(1) the development and operation of this system of health care in a manner and to the effect that just and equal consideration be given to the interests of all concerned—government, patient and physician; (2) we must retain our prerogatives as citizens, who, by the exercise of freedom in speech, thought or action may and should seek any just means of amending or altering this socialistic experiment, or of even taking the proper means of preventing its further spread in our political and social system; and (3) let us refrain from any action or word which could lead to or condone any unjust criticism of our profession should this system fall into disrepute or fail to accomplish the desired ends.

The President has established a new record of official visitations to the component societies. He has visited 20 of the 28 societies in our State, and surely would have included the other eight had he been invited, as provided in our By-Laws. During these official visits he has met with the officers of each component society for a discussion of mutual problems, a very worthy action which can well be recommended to his successors in office. In this same category of action, the President called together the officers of all societies for a central workshop, which was attended and addressed by the President Elect of the American Medical Association.

There has been occasional and repeated criticism of our present distribution of Councilor Districts, which as you know, is based upon the congressional district geographical factors. As the result of a resolution adopted by the House of Delegates at the 1965 Annual Meeting, a special committee, chaired by Dr. Kenneth G. MacDonald was directed to study the matter and report at this annual meeting. The study was thorough and discussion was ardent at times. We are indebted to our sister State of Ohio to the extent that its councilor district set-up was considered in the final recommendations which were transmitted to the Committee on Constitution and By-Laws, as is provided for in the By-Laws. Because of the geographical terrain and the location of urban areas in our mountain state it is literally impossible to redistribute our Council Districts in a manner which will please every county society and yet maintain a just representational balance. Your Committee on Constitution and By-Laws has offered a proposal for redistribution of Councilor Districts upon which this House of Delegates must take action. This plan, like any other proposal, will require amendments to both the Constitution and By-Laws, and hence can only be completely effected a year from this date. If the House is determined to start with, and maintain a balance between new blood and experience in the Council, then one-half of the Councilors elected next year might possibly be limited to but three years service in Council instead of the present constitutional privilege of a maximum of four years' continuous service. Doctor Parks is to be commended for his active influence in attaining this objective.

For several years there has been discussion in the realm of realignment of the alleged inequity in the present allocation of delegates in the House. The Committee on Constitution and By-Laws has transmitted to the House at its first session, a proposed change in county society delegate representation, which will decrease the number of delegates from 15 of our smaller societies and increase from one to seven the number of delegates from six larger societies. It will be the responsibility of this body to make a final determination in this matter later today.

The members of this Committee wish to accentuate the statements made by our President in his remarks anent the Woman's Auxiliary. Mrs. Wilson P. Smith and the members of her organization have done outstanding work on the State and local level, even to recognition of their efforts by the American Medical Association in its recent annual meeting.

It is impossible, within the scope of a report such as this, to enumerate and place proper emphasis on all the desires and accomplishments of Doctor Parks' administration. Your Committee, however, wishes to request that its report on the Presidential Address shall be approved by a standing vote of the House of Delegates, as a visible and heartfelt gesture of gratitude and appreciation for a responsibility accepted with courage and determination, and fulfilled in a manner which does honor to himself and to his profession. Mr. Chairman, I so move.

Respectfully submitted,

James S. Klumpp, M. D.
Chairman
George F. Evans, M. D.
J. C. Huffman, M. D.

August 27, 1966.

*Other annual reports were published in the August 1966 issue of The Journal.

Insurance Committee

Our Group Insurance Program is operating at an all-time high, both in member participation and service rendered.

Over 80 per cent of our eligible members are now participating in one or more of the plans available. Seven separate plans, each providing an essential form of personal protection, are available for the benefit and use of our members. This choice of plans and the broad flexibility of coverage within each plan enable a member to assemble a comprehensive package of protection specifically designed to meet his own individual needs. Furthermore, due to the wholesale buying power of the Association and the economies of group administration, coverages are obtained at rates substantially below comparable coverage usually available on an individual basis.

Service continues to be the keystone of our program. All policy services, including the processing and payment of claims, are provided by our resident administrator. A qualified staff completely specialized in the operation of association group insurance administers the Program. A service representative travels the state and is always available for consultation and assistance when called upon in the filing of claims. The advantage of this wide scope of coverage, low group rates and complete claim service here in the state cannot be over-estimated.

Our Association can certainly take justifiable pride in this Association sponsored service that contributes so much to the protection and security of our members and their families.

Two significant developments have occurred during the past year. First has been the extraordinary response to the jumbo Accidental Death & Dismemberment insurance. This coverage offers a member up to $100,000 Accidental Death & Dismemberment with an optional provision of up to $50,000 for his wife. The combination of increased travel and the other hazards of our day, plus extremely favorable rates apparently accounted for the large response. Over 500 of our members and their wives are now covered under this plan.

The other development is the substantial increase in participation in Loss of Time and Major Hospital plans. This increase is attributed in part to the ever-growing reputation of our State Program for sound protection and efficient service. Another contributing factor was the discontinuance of group insurance programs in three of our component societies. Most of the members in these County Component Plans converted to the State Program.

We are prompted at this point to re-state the fact that administration of Association Group Insurance at the state level provides the two basic essentials for sound performance—a large enough membership for actuarial stability, a small enough area for adequate policy service. Our own success for the past eighteen years is a clear demonstration of this fact.

Our new Life Plan will provide up to $40,000 life insurance in $10,000 increments. This low cost coverage offers a significant addition to a member's life estate at a very low cost. This program is certainly worth your consideration.

In summary, your Association Group Insurance Program continues to serve our membership efficiently and well. We are now in our 18th year of operation with a consistent record of steady growth and sound performance. It shall be the continuing purpose of your Committee to see that the present high level of performance of our Group Insurance is continued and to remain constantly alert to the prospect for new coverages, improvement in existing coverages and within the framework of group administration provide the best possible service.

Recognition should be given to Mr. J. Banks Shepherd, our coordinator, and his staff for their continuing efforts to make our Insurance Program one of the finest in the country.

Respectfully submitted,

C. A. Hoffman, M. D., *Chairman*
W. P. Bittinger, M. D.
Robert L. Chamberlain, M. D.
R. U. Drinkard, M. D.
Upshur Higginbotham, M. D.
Athey R. Lutz, M. D.
Kenneth G. MacDonald, M. D.
Joe E. McCary, M. D.
Buford W. McNeer, M. D.
Andrew J. Weaver, M. D.

August 27, 1966.

Medical Education and Hospitals

Your Committee on Medical Education and Hospitals has involved itself with two basic concerns during the past year: the physician shortage in West Virginia and the need for a coordinated program of postgraduate education for practicing physicians of the State.

The Committee studied at length a recommendation by Dr. Albert C. Esposito in his presidential address in August, 1965, that a two-year medical school be established in the Huntington-Charleston area as a means of attracting more physicians to practice in West Virginia. It is the judgment of your Committee that this proposal is not practical at present. At a meeting in Charleston on February 20, 1966, the Committee stated its position thusly:

> "This Committee regards the establishment of another two-year medical school as unfeasible and (recommends) that attention be directed instead toward expanding the present facilities of the West Virginia University School of Medicine so as to double its present enrollment and production of graduates within the next few years."

Five months later, on July 17, 1966, Dr. Clark K. Sleeth, Dean of the WVU School of Medicine and a member of this Committee, reported to the Committee that the School will enroll 70 students in the first-year class in September 1967, an increase of 10 over previous years. The ability to expand further, he said, would depend on the ability to find adequate financing. To double the size of each class, he added, would involve an increase of one-third in personal services and operating funds and an uncertain capital outlay.

Realizing that increasing the number of medical school graduates in itself will not necessarily alleviate the physician shortage, the Committee adopted this statement on February 20:

> "In order to render the highest standard of medical care to the people of West Virginia, the Committee advocates: (1) broadening the medical education of our medical students by the WVU Medical Center in cooperation with the State Medical Association by establishing supplemental instruction in the clinical years in other geographical areas in our State, (2) coordinating and improving graduate intern and resident programs, (3) providing increased postgraduate education for the practicing physicians of our State, and (4) rendering more attractive the practice opportunities for the new physicians in our State."

This statement epitomizes all of the basic concerns of your Committee.

Insofar as the education of our medical students is concerned, your Committee is of the opinion that the rotation of third and fourth-year medical students to various cities where they could receive training in community, industrial, rehabilitative and social medicine would enhance their training. Wherever they might be assigned, they would remain under the administration and supervision of the WVU School of Medicine. It might be noted here that Doctor Sleeth is in accord with this concept provided that all members of the third and fourth-year classes are rotated periodically.

Your Committee has not explored what this concept might entail in terms of off-campus faculty and facilities.

Before the year is over, the Committee expects to take definite steps toward establishing a sound program of postgraduate education for West Virginia's practicing physicians. The Committee has divided the State into eight geographical areas for the administration of this program, which will be developed in detail later. The areas are as follows:

Area 1—Monongalia, Preston, Marion, Harrison, Taylor, Tucker, Barbour, Lewis, Upshur and Randolph Counties.

Area 2—Wetzel, Marshall, Ohio, Brooke and Hancock Counties.

Area 3—Jefferson, Berkeley, Morgan, Hampshire, Hardy, Pendleton, Grant and Mineral Counties.

Area 4—Tyler, Doddridge, Gilmer, Ritchie, Pleasants, Wood, Wirt, Calhoun and Jackson Counties.

Area 5—Boone, Fayette, Nicholas, Webster, Braxton, Clay, Roane, Putnam and Kanawha Counties.

Area 6—Mingo, Logan, Lincoln, Wayne, Cabell and Mason Counties.

Area 7—Pocahontas, Greenbrier, Monroe, Summers and Raleigh Counties.

Area 8—McDowell, Mercer and Wyoming Counties.

These boundaries are defined for convenience and administration only. Physicians will not be restricted from attending educational programs outside their own areas.

Originally, your Committee considered correlating the state-level educational program with the "core curriculum" concept that was being developed by the American Medical Association. However, the AMA House of Delegates abandoned that program during the Annual Meeting in Chicago last June.

Members of your Committee at the present time are surveying the eight geographical areas to determine educational needs and resources in each. Already, reports have been submitted on three areas, and those on the remainder should be submitted later in the year.

The advice and help of other professional groups is being sought. Your Committee is planning a State Education Meeting in Charleston on November 13. Representatives of the West Virginia University School of Medicine, the teaching hospitals of the State, the professional societies, voluntary health agencies and public health agencies will be invited. The purpose of this meeting will be for the Committee to receive advice on the State's problems of graduate and postgraduate medical education and regional and statewide solutions presented in the hospital-oriented and regionalization concept.

Respectfully submitted,

Pat A. Tuckwiller, M. D.
Chairman

August 9, 1966.

Report of the Chairman of Council

In this past year, your Council met five times to consider the many, many problems which were presented and which affected medicine in West Virginia.

In keeping with last year's Presidential Address, Council considered my various recommendations with the following action:

1. In reference to a proposed new two-year school of medicine, the matter was referred to the Committee on Medical Education and Hospitals. After much study, it was recommended, and Council approved, that the present West Virginia School of Medicine increase its enrollment as funds permit and that the third and fourth clinical years be held in "other geographical locations in the State." Council will continue to study the medical manpower shortage in our State and make additional recommendations as the situation merits.
2. After the enactment of the dues increase the proposed new budget which has been our goal for many years was enacted and approved for the first time.
3. As recommended last year, Council approved increased financial aid to our Auxiliary, permitting for the first time no registration fee for the Auxiliary at this convention.
4. After the enactment of the new Constitution and By-Laws, Council authorized their distribution to each member of this Association.
5. As a further means of closer liaison among our component medical societies and your Council and the State Medical Association, it was recommended that each of the Councilors be made advisors and members of their component medical society executive committees.

6. After many years of endeavor, Council this year authorized the first County Medical Society Officers Conference with projected plans to make this an annual affair.
7. Two resolutions were submitted by our American Medical Association delegates to the American Medical Association House of Delegates at the suggestion of Council.

This year Council has, as you well know, been preoccupied with the many facets of the national and regional health legislation already passed. After much study:

1. Council recommended that we choose the usual and customary charge as our fee for service in these health programs; and
2. That we be urged to bill the patient directly for all such services under these programs.
3. Council further approved and your hard working Medical Economics Committee sent you detailed reports on methods of billing for each of the agencies concerned.
4. Council considered in detail the Guidelines of the Appalachian Regional Program and strongly urged revisions and deletions of the Guidelines to the Appalachian Commission in an endeavor to make them conform to our present concept of medical practice.
5. Council further suggested and approved of a Liaison Committee to work with the Ohio State Medical Association in reference to Medicare and the Appalachian Program.
6. It also approved of an advisory committee to the Board of Health and to Governor Hulett C. Smith of West Virginia.
7. Council authorized a workshop on Medicare in cooperation with the West Virginia Hospital Association and plans to have another such workshop in the coming year.

Of much concern to Council has been the Supreme Court of West Virginia's ruling on our malpractice law. This is of vital concern to each and everyone of us. In view of this, Council has authorized our legal advisor to send each of you a letter explaining the seriousness of this matter. It was approved and should reach you sometime soon. Please read this letter very carefully.

At this morning's session of the council of the West Virginia State Medical Association, several changes in the By-Laws were considered and will be reported to you by Dr. James S. Klumpp, Chairman of the Constitution and By-Laws Committee.

We heard from Mr. L. L. Vincent, Commissioner of the Department of Welfare and are in the process of finalizing a settlement of charges for services to his department.

Our Medical Economics Committee Chairman discussed in detail the Committee's recommendations and the happenings up to this moment. You will be kept fully informed.

We were honored in also having Dr. Charles L. Hudson, President of the American Medical Association, present at this morning's Council meeting.

As Council comes to the end of another year, we owe a debt of gratitude to all its members and especially to those members who are now leaving Council: Dr. Charles L. Leonard of Elkins; Dr. William B. Rossman of Charleston; and Dr. Richard W. Corbitt of Parkersburg.

As I leave you, last year as your President and now as your Chairman of Council, I want to thank you for the privilege of serving medicine during these past two years. They shall be filled with pleasant and troublesome memories but I am happy in knowing that during all this time, I have truly tried to do my best for you and medicine in West Virginia.

Respectfully submitted,

Albert C. Esposito, M. D.
Chairman of the Council

August 24, 1966.

Necrology Report

The following is a list of West Virginia physicians whose deaths have been reported to the West Virginia State Medical Association during the past year:

1965

Sept. 6—C. R. Kessel	Ripley
Sept. 10—Charles L. Goodhand	Parkersburg
Sept. 29—O. L. Hamilton	Huntington
Oct. 1—Vincent T. Churchman, Jr.	Charleston
Oct. 4—T. T. Huffman	Keyser
Nov. 11—Cole D. Genge	Huntington
Nov. 21—R. L. Calvert	Spencer
Nov. 28—Milton S. Duling	Charleston
Dec. 4—Clyde W. Vick	Bluefield

1966

Jan. 15—Harlan A. Stiles	Huntington
Jan. 15—M. B. Williams	Wheeling
Jan. 21—William M. Hall	Parkersburg
Jan. 24—Charles O. Reynolds	St. Petersburg, Fla.
Jan. 28—Herbert B. Copeland	Wheeling
Jan. 29—Byron William Steele	Mullens
Feb. 20—E. S. Brown	La Canada, Calif.
Feb. 27—F. L. Banks	Beckley
Feb. 28—Claude L. Houck	Lewisburg
Mar. 1—Robert B. Price	Charleston
Mar. 17—Edmund O. Gates	Welch
Mar. 17—J. W. Myers	Moundsville
April 3—C. J. Holley	Bridgeport, Ohio
May 4—Arley V. McCoy	Elm Grove, Wheeling
May 12—Henry R. Glass	Charleston
May 22—Herbert N. Shanes	Grafton
May 28—Harold W. Ulch	Parkersburg
May 31—Ray Kessel	Ripley
June 2—Raymond H. Dunn	Lewisburg
June 9—Carl J. Carter	Fairmont
June 22—E. L. Justice	Weirton
July 2—William Harry Boone	Keyser
July 20—J. M. Cofer	Webster Springs
Aug. 1—N. B. Hendrix	Martinsburg
Aug. 15—Clark Kessel	Beckley
Aug. 18—Harold P. Evans	Keystone

Respectfully submitted,

William H. Lively,
Executive Secretary

August 24, 1966.

Resolutions

Resolutions offered at the first session of the House of Delegates on Wednesday afternoon, August 24, 1966, were referred to the Committee on Resolutions for study and report back, with recommendations, at the final session on Saturday afternoon, August 27.

Dr. Maynard P. Pride of Morgantown, the Chairman, presided at a meeting of the Committee which was held on Thursday afternoon, August 25.

Upon request by the sponsors, two resolutions regarding apportionment of the Council and the House of Delegates were withdrawn from consideration.

As recommended by the Committee, the House of Delegates adopted the following resolutions:

Resolution No. 1. Hospital Contracts—By the Executive Committee of the Parkersburg Academy of Medicine.

WHEREAS, the Medicare Law (PL 89-97) establishes separate provisions for hospital care and for coverage of hospital based physicians' services; and

WHEREAS, The West Virginia Code prohibits the practice of medicine by a lay-corporation whether or not organized for profit; and

WHEREAS, The national governing bodies of the concerned physician specialists and the American Medical Association have issued policy statements recommending fee for service arrangements and direct billing of individual patients;

NOW, THEREFORE, BE IT RESOLVED, That the West Virginia State Medical Association endorse and actively support the position of all hospital based physicians in altering whatever hospital contracts as are necessary to establish a normal and ethical relationship as soon as practical but no later than December 31, 1967; and

BE IT FURTHER RESOLVED, That the House of Delegates of the West Virginia State Medical Association instruct the Council of the West Virginia State Medical Association to petition the Commissioner of Insurance of the State of West Virginia to require removal from all prepaid hospital insurance plans provisions for benefits covering hospital based physicians' services.

* * * *

Resolution No. 3. Medical Programs Under the Direction of the State of West Virginia—By the Kanawha Medical Society.

WHEREAS, The West Virginia State Medical Association is deeply concerned with the administration of medical care programs under the direction of the State of West Virginia; and

WHEREAS, The Association is deeply concerned with the effect of the extent of and restrictions in medical services available to residents of the State of West Virginia under these programs;

THEREFORE, BE IT RESOLVED, That the West Virginia State Medical Association make known these concerns to the Governor of the State of West Virginia and urge that the Governor seek consultation and recommendations prior to the appointment of directors or commissioners and members of boards or advisory committees of departments of the State of West Virginia under whose authority medical care programs are administered.

Resolution No. 4. Doctor-Patient Relationship—By the Kanawha Medical Society.

WHEREAS, Physicians are vitally concerned with the maintenance of rapport between doctor and patient; and

WHEREAS, Our concern in the third - party medicine is principally the result of our fear of interference in this vital relationship; and

WHEREAS, The attending physician stating when a patient is physically able to return to his previous occupation or to other forms of gainful employment frequently interferes with the usual doctor-patient relationship, particularly where the patient may suffer financially as the result of such statements; and

THEREFORE, BE IT RESOLVED, That the West Virginia State Medical Association supports the right of the attending physician to state only his patient's physical incapacity and not when his patient is capable of returning to his previous occupation or other form of gainful employment, if in his medical opinion such a statement shall interfere with the normal doctor-patient relationship and/or his patient's future health care.

Report of Resolution Committee

The Chairman of the Committee, Dr. Maynard P. Pride of Morgantown, submitted his report to the House of Delegates at the final session on Saturday afternoon, August 27, 1966. The report follows:

"Your Committee on Resolutions has carefully considered the resolutions offered before the first session of the House of Delegates on Wednesday afternoon, August 24, 1966.

"Several members of the Association appeared at a meeting of the Committee held on Thursday afternoon, August 25, 1966, and discussed in detail the resolutions pending before the Committee. The cooperation of these physicians has been most helpful to the Committee in reaching decisions, and we express appreciation to those who took time to attend the open hearing.

"Mr. President, your Committee assures the members of the House of Delegates that the one and only consideration that has guided the Committee in its deliberations has been the criteria as to whether each of the resolutions were or would be to the best interests of the entire medical profession in West Virginia.

"Mr. President, we wish to thank the members of the West Virginia State Medical Association who appeared before the Committee at the open hearing on August 24, 1966.

"Your Chairman personally expresses his gratitude to the members of the Committee for the patience, enthusiasm, wisdom and valuable time devoted to the study of the resolutions.

"In addition to your Chairman, the members of the Committee participating were Drs. Albert C. Esposito, Huntington; J. C. Huffman, Buckhannon; Kenneth G. MacDonald, Charleston; and Mr. William H. Lively, secretary ex officio."

Obituaries

FREDERICK EUGENE AMICK, M. D.

Dr. Frederick E. Amick, who practiced pediatrics in Huntington since 1948, died in that city on August 28 of a heart attack. He was 50.

A native of Richwood, Doctor Amick attended Marshall University and George Washington University before receiving his M.D. degree from the George Washington University School of Medicine in 1943.

He interned at Charleston General Hospital and served a residency at Gallinger Municipal Hospital in Washington, D.C., 1946-48. He was a member of the Cabell County Medical Society, the West Virginia State Medical Association and the American Medical Association.

During World War II, he served for 27 months in the Medical Corps of the United States Army.

Survivors include the widow; a son and a daughter; and two brothers, John of Pine Bluff, Arkansas, and Brooks of St. Louis.

* * * *

HAROLD PARRIOTT EVANS, M. D.

Dr. Harold P. Evans, 72, Keystone, died in a Welch hospital on August 18 following a brief illness.

A native of Bannen, Doctor Evans had resided at Keystone since 1923. He had served as company physician for Eastern Associated Coal Corporation in Keystone for 43 years and practiced until shortly before his death.

Doctor Evans received his M. D. degree from the University of Maryland in 1920. His professional memberships included the McDowell County Medical Society, the West Virginia State Medical Association and the American Medical Association; the Southern Medical Association; and the Association of American Physicians and Surgeons.

Doctor Evans leaves his widow, Mrs. Maude H. Evans; and two brothers, Dr. Brooks B. Evans of Charleston and Ralph W. Evans of Cameron.

* * * *

GEORGE GALEN HODGES, M. D.

Dr. George G. Hodges, 80, of Mount Hope, died in an Oak Hill Hospital on September 4 after a brief illness.

A native of Kentucky, Doctor Hodges received his M.D. degree in 1909 from the University of Louisville School of Medicine. Following his graduation, he located his practice at Dry Branch in Kanawha County, where he remained for 10 years.

He was a coal company physician from 1922 until 1940, when he transferred his practice to New River.

Doctor Hodges was an honorary member of the Fayette County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow, Mrs. Jenny Duncan Hodges; and a sister, Mrs. T. A. Holman of Charleston.

* * * *

HAMIL CLARK KESSEL, M. D.

Dr. H. Clark Kessel of Beckley died at his home on August 15 of an apparent heart attack. He was 63.

Doctor Kessel was born in Ripley but had been a resident of Raleigh County for 33 years. He received an A. B. degree from Marshall University in 1928 and earned his M. D. degree at Jefferson Medical College of Philadelphia in 1932.

He was a former officer of the Raleigh County Medical Society and was a member of the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow, Mrs. Edna Lilly Kessel; one daughter, Mrs. Richard (Linda) Meckfessel of Charleston; one son, H. Clark, Jr., at home; two sisters, Mrs. Russel D. Hutchison of Ripley and Mrs. James Dunn of Meadeville, Pennsylvania; two brothers, D. Wade and James C. of Ripley; and two grandchildren.

* * * *

LESTER DIMMITT NORRIS, M. D.

Dr. Lester D. Norris of Fairmont, one of the first physicians in West Virginia certified in any specialty, died in a Fairmont hospital on August 27. He was 81.

Born in Baltimore, Doctor Norris received his M. D. degree from the University of Maryland Medical School in 1908. He interned at University of Maryland Hospital and took training in anesthesiology at Lakeside Hospital in Cleveland in 1918. He was one of the first diplomates of the American Board of Anesthesiology.

Doctor Norris was a Fellow of the American College of Anesthesiology and was a member of the Marion County Medical Society, the West Virginia State Medical Association and the American Medical Association. He served a term as President of the local society.

Survivors include the widow, Mrs. Adelaide H. Norris; a daughter, Mrs. Urban W. (Mary Louise) Boresch, of Grosse Pointe, Michigan; and a sister, Mrs. J. Graham Shannihan of Baltimore.

* * * *

WALTER WILLIAM SPELSBURG, M. D.

Dr. W. W. Spelsburg, 65, of Clarksburg, died in a hospital in that city on August 25.

A native of Germany, Doctor Spelsburg received a B. S. degree at West Virginia University in 1923 and earned his M. D. degree at the University of Maryland College of Medicine in 1925. He was a former member of the Harrison County Medical Society, West Virginia State Medical Association and the American Medical Association.

His specialty was ophthalmology and otolaryngology.

Survivors include the widow, Mrs. Marian Reid Spelsburg; two sons, Dr. Walter William Spelsburg, Jr., of Pasadena, California, and Thomas C. Spelsburg of Morgantown; three daughters, Mrs. Frank (Marian)

Stevens of Maple Lake; Mrs. Richard (Carolyn) Shiben of Silver Spring, Maryland; and Mrs. C. Richard (Linda) Wolfe of Newark, Delaware; two brothers, Albert Spelsburg, Jr., of Clarksburg and Charles Spelsburg of Clarksburg; two sisters, Mrs. H. G. Fretwell of Charleston and Mrs. William H. Coston of Clarksburg; and 11 grandchildren.

The Case of the Therapeutic Establishment

The problems and responsibilities of government in assuring the safe use of drugs are indeed formidable. This brings up the whole question of efficacy and relative efficacy; and who is going to dogmatize on this? Again, who is going to say that the occasional fatal toxic reactions which may result, for instance, from the use of psychotrophic drugs in depressive illnesses are or are not greater than the danger of an increased incidence of suicide if such drugs are forbidden.

Doubtless a committee of experts will advise the appropriate Ministers, and if experts are occasionally wrong they are less often wrong than non-experts. Nevertheless, we interfere with the prescribing doctor's final freedom of decision at our peril in a free democracy. It is easy to set up a sort of pontifical therapeutic Establishment; but Establishments—Aristotle and Galen, for instance—have not always been in the van of progress.—Sir Derrick Dunlop, M. D., in *British Medical Journal.*

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The West Virginia Medical Journal

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Are We Creating Our Own 'Big Brother'?*

Charles L. Hudson, M. D.

Our lives are greatly influenced by the ideas of other people, particularly those of the great thinkers we have learned to admire and respect. One man who has had a degree of influence in recent years is George Orwell, who wrote a novel called "1984". It was published only a dozen years ago. It put into our language for all time the expression, "Big Brother is Watching." Big Brother, you remember if you read this terrifying book, was the otherwise unidentified head of the government.

There is no freedom in 1984, neither of action nor of thought. Every house, for example, is equipped with a built-in television set, which can be turned on or off only at a government control room. Its screen is two-way. It not only shows government-produced programs to viewers at home, but also provides a view of the home to supervisors who monitor from headquarters. Members of any family are occasionally ordered to stand in front of the screen and submit to a visual search as they turn out their pockets and open their purses and brief cases.

When Orwell wrote this book, 1984 seemed to be a very distant time. But when we think about it today, we realize that after the terms of the next four presidents of the United States, we shall have arrived at the year 1984.

I am neither implying nor threatening that by the time we reach that year we shall also reach the kind of world Orwell painted so graphically. However, there are indications of accelerating movement toward more centralized government that we would be foolish to ignore.

Free Enterprise Threatened

We find that free enterprise and the operation of the free market have been threatened, and not only influenced but changed by the will of government. People in the steel, copper and aluminum industries can testify as to what happened when circumstances made it necessary for them to raise prices, but the Federal Government did not want the prices raised.

Control over contracts, raw materials and surpluses that could be released to overwhelm the market made it relatively easy for the government to force these companies to do what it wanted them to do, rather than what the operations of a free market dictated they should do.

Granted, I'm drawing a black picture. I'm not nearly so pessimistic as I sound, but if our way of life should come to an end, we could not say it has not been prophesied many times. It is worth noting at this period in our history that no democracy similar to ours has ever lasted more than 200 years; and this nation will be 200 years old in only a few years.

The English statesman, poet and historian Thomas Macauley, who died more than a century ago, made a study of United States public affairs in the first half of the 19th century and saw danger ahead for us. He said this:

> "Your constitution is all sail and no anchor. Either some Caesar or Napoleon will seize the reins of government with a strong hand, or your republic will be as fearfully plundered and laid waste by barbarians in the 20th century as the Roman Empire was in the fifth. With this difference: that the Huns and Vandals who ravaged the Roman empire came from without; and your Huns and Vandals will have been engendered within your own country, by your own institutions."

The Author

- **Charles L. Hudson, M. D., Cleveland, President, American Medical Association.**

*Presented before the First Session of the House of Delegates at the 99th Annual Meeting of the West Virginia State Medical Association in White Sulphur Springs, August 24, 1966.

The People Are Responsible

If the United States is heading toward a Big Brother type of government; if freedom is to be replaced one day by any form of totalitarian control; the really frightening, as well as the truly sad, thing about it is this: the people themselves have brought it about.

This nation and its government were so established under the constitution that a despot cannot seize power from within. The only possibility is that under the constitution itself, the people voluntarily give dictatorial power to a man or coalition of men they believe can be trusted with it.

That is what I fear most: that we, the people of the United States, are creating our own Big Brother.

Emerson told us that the true test of a civilization is not the census, nor the size of the cities; but the kind of man the country turns out. It appears to me that more and more, we are now turning out the type who wants everything done for him. He does not want the inconvenience and bother of having to do things for himself. He is willing to abdicate his responsibility and give up his freedom of choice in order to be taken care of.

We seem to be getting farther and farther away—not just in time, but in attitude and in courage—from our pioneer forefathers we admire so much, but whom we no longer want to emulate.

The hardy people who got into covered wagons to cross a wilderness filled with unknown dangers; who risked starvation and suffered thirst in order to find a place where they could be free, are the ancestors of today's men and women who demand increases in Social Security benefits so they don't have to worry about saving for the future.

The courageous and resourceful people who grouped together to fight off Indians, clear trees, plant crops and build their own homes of logs and mud are the progenitors of people who are clamoring today for government-subsidized rent payments and federal housing in which they can live at little or no cost.

Rights Carry Responsibilities

Too many people in our country—and I don't restrict this to any minority group—are making a great deal of noise demanding rights, demanding opportunity, demanding possessions. What they overlook is the age-old truth that if there is to be freedom, then every right must carry its responsibility; every opportunity, its obligation; and every possession, its duty.

It seems now that for every problem, whether for a state, a city or an individual, we turn immediately to Washington for the solution. We think whatever must be done—for ourselves, for our communities, for our states—can be done only by the Federal Government.

People being what they are—which means politicians being what they are too—the government is accepting these responsibilities. Indeed, it is accepting more responsibility and accompanying increases in power with enthusiasm.

Our national leaders, our elected representatives, are not going to turn their backs on the people from whom they get their positions and their authority; the people who can elevate those positions and magnify that authority. What the people want, the people will get. That is the whole basis of representative, free government.

That is the devastating thing about the situation. The conservative sees what is happening, but he cannot rightfully berate Washington for it. He must berate the people who are making it possible.

"The fault . . . lies not in our stars, but in ourselves, that we are underlings." So said Shakespeare. I would paraphrase him to say the fault lies not in the White House, but in our voting booths, that we are being overwhelmed by federal programs.

Government in this country derives all of its power from the consent of the governed. If it becomes the consensus of the governed that they give up all decision-making to Washington, then Washington is not only willing, but virtually obligated, to accept.

Government's duty to serve the will of the people was built into our system of government. It was a startling innovation in governmental concept. At the time it was instituted, I'm sure it didn't occur to the architects of our nation that the people would ever want their government to do more than it absolutely had to do.

Having watched freedom-seeking people come here to escape oppression under European governments, the founders of this country surely couldn't imagine that Americans would ever want more than minimal government.

Trade Freedom for Financial Welfare?

After seeing them fight and win a devastating war for independence against what was then the strongest nation in the world, what prophet could have foreseen that Americans would one day rush to their nation's capitol offering to trade their freedom for financial welfare? I want to make it clear that I do not believe it is fair or

correct to blame only the political leaders of this country—of either party—for the trends that are undermining our traditional freedom. Nor can we blame the philosophy of either party. The blame, if that is the word to use, lies solely with the people. The nation's political leaders are responding to demands being put upon them by their constituents.

While we can wish that the political minds were oriented differently; and wish that more of our leaders would fight against these trends instead of encouraging them; nonetheless it is the people —the vast majority of the people—who, first, are placing more demands on the government and, second, are rushing to embrace every new program proposed by the government.

As our government responds to more of these demands, and plays the game by offering more new programs, it becomes necessary that more and more of our national financial resources be funneled to Washington to finance these programs. Even so, however, the increasing amounts of tax revenue collected have been unable to keep pace with the increasing expenditures.

I am neither so naive nor so radical as to say unequivocally that government spending should stop. There are too many services that can only be provided, and too many projects that can only be successfully executed in a nation such as this one by a strong Federal Government. As the number of people in any society—a tribe, a community, a state or a nation—increases, so do the amount and kinds of services the society's government must provide. I know that. So does everybody else, including the most rabid critics of government.

Demands for Unnecessary Services

The danger is not that government must continue to offer more necessary services; the danger to freedom lies in the constant proliferation of demands by the people for government services that are not necessary.

The Federal Government is asked to do a multitude of things for us that we ought to be doing for ourselves. It is asked to solve problems that should—and could—be solved at the community level. It is asked to furnish things for the individual that he ought to provide for himself.

Again there are exceptions, of course. I would not arbitrarily remove all names from the welfare rolls and wipe out the government's obligations toward those who are its dependents through circumstances they cannot control. Under the jurisdiction of every level of government there are people who must be helped—children without parents; elderly people without means of their own and without children to offer support; the disabled, many of whom became so in the service of their country; and others who have just cause to expect help from their government. This is much too wealthy a country for people to be in dire want because they are genuinely unable to provide for themselves.

But the necessity for helping certain of its citizens does not indicate a need to extend the same help to everybody. The government does not owe all of its citizens a living; it only owes to them a governmental climate in which there is opportunity for everybody to make his own living. There is a vast difference in these two concepts which many people fail to comprehend.

The province of government in this country is to maintain and reinforce the climate of free enterprise established by the constitution, in which individual initiative can be exercised in the hope of claiming a reward. If such a climate is allowed to deteriorate, initiative will also slowly but surely evaporate.

People must be made to see that if they give up their initiative to the government, and demand that things be done for them they should do for themselves, eventually they will lose entirely their ability to do for themselves. Then, instead of only being beneficiaries of the government's generosity, they will be helpless dependents on the government's will.

Teaching Responsibility

In rearing children, parents almost instinctively know that to turn a boy into a man, or a girl into a woman, the child must be given and taught to accept responsibility. Dad might be close at hand, but a boy has to learn to pedal alone if he is ever going to ride a bicycle. This same instinctive knowledge must be applied to our lives as adult citizens. But none of us is ever going to be able to ride a bicycle alone if we beg Uncle Sam to run along beside us all the way, hold the seat and never let go.

The tragedy of growing dependency on the Federal Government, first, is the inevitable loss of the individual's resolve for self-help. Once he gets in the habit of looking to the government for his needs, he will lose the habit of even trying anything for himself.

The second step in dependency on government is the development of a sense of entitlement. When people have received a few things from the government in the form of largess, they become entitled, in their own minds, to other things.

Case Report

I remember a beggar who, for a long time, sat outside the entrance to a hospital next to the

physicians' parking lot. A doctor I know felt sorry for the man, who was crippled, and one day he gave him a dollar. The man's gratitude was touching and made my friend feel good. All of us feel good when we've done something that makes somebody happy. The next day the act of generosity was repeated, with the same joyful results.

This went on for some time. Every time the doctor entered the hospital, several days a week, he gave the beggar a dollar. And a perfectly natural thing happened. The beggar stopped expressing his gratitude, and began only nodding an acknowledgement. This was all right, of course; nobody wants to hear a speech of thanks over and over.

Then one day the doctor came to the hospital quite worried about the progress of a patient he was to see. He walked past the beggar without seeing him. Just as he was entering the door, the beggar shouted after him: "Hey," he said, "you forgot my dollar."

The dollar was no longer a gift to be appreciated. It had become a right to which he was entitled. Sincere gratitude had turned to simple thanks; and then to demand.

The same thing can happen in the individual's relationship with his government. Everything he receives—above the necessities for which government was established—whets his appetite for more, until finally he comes to believe there is nothing he can want that the government shouldn't give him; that whatever it takes to fill his needs is due him.

At that point, he ceases to be a citizen and becomes a dependent, not only permitting and encouraging the government to meet his needs, but very quickly allowing the government even to decide what those needs are.

Having arrived at a logical point where a conclusion to this talk is in order, I daresay each one of you could now rise and add your own examples of the detrimental effect of this trend toward dependency on government. Or you could tell how the enthusiastic and uncritical embracing of programs suggested by the government has affected your life or that of persons you know.

Obvious Dangers

Since there is not time to open this to forum discussion, however, I ask your permission to continue by pointing out some of the more obvious dangers inherent in this trend as it affects the medical profession.

I would like to begin by pointing out that the real significance of Medicare is not so much the implementation, vexatious as it is, but that we have an entirely new concept of governmental support to American health care progarms.

Government-paid health care dates back at least to 1883, when Bismarck instituted a national health program for the Germans with the admitted purpose of making his subjects feel obligated to their government—which meant to Bismarck.

The idea of health care supported by the government has been adopted to varying degrees in many countries during this century and was first seriously proposed here in 1930. In 1936, the commission whose work led to the Social Security Act also proposed a national health service, but again the Congress wisely declined.

This is not to say our government was not involved in health care financing prior to Medicare. As a matter of fact, the government has been spending nine billion dollars a year on health programs—approximately one-fourth of the total spent on all health care in the United States. There are programs of the Department of Health, Education and Welfare; the U. S. Public Health Service, the armed forces, for members and their dependents; the Indian Service; and others, including programs for federal employees.

But all of these programs helped persons who were otherwise dependent on the Federal Government to some degree—as employees, for example; as members of the armed forces; or as persons needing assistance because of poverty or physical impairment. Medicare is unique in that it dispenses with all eligibility qualifications except the attainment of a certain minimum age.

It was this feature of Medicare, the elimination of reasonable criteria for eligibility, that the medical profession opposed, and had opposed for 20 years or more.

Medicare Proponents Will Not Rest

We are certain now that proponents of Medicare, elated by their initial victory, will not rest their efforts to expand the social insurance principle until they ultimately make health care for everybody in the country a financial responsibility of the Federal Government.

If the people of our country give up their responsibility for paying the bill—for medical care or anything else—they also must be prepared to give up their choice as to where, how and from whom they will receive benefits.

Mr. Richard Nixon, former Vice President of the United States, put it well at the American Medical Association's annual convention in June: "I want to pay the doctor bill myself," he said. "I want the doctor to feel he is working for me."

It is just as true that we physicians also want to feel we are working for the patient. We do not want to become an employee of the government bureau administering the health care program.

Of many other foreseeable disadvantages in the expansion of Medicare to a national health program, I shall touch on only one. Medical care is now financed from a variety of sources, including the Federal Government along with private individuals, institutions, foundations and so forth. If medical care becomes the responsibility of the government, solely, those private sources will disappear. Once the federal treasury has the only funds for medical care, national medical expenditures immediately become subject to budget cuts in favor of other government programs that appear to have more immediate urgency. In other words, the provision of medical care could—and doubtlessly would—be hampered by fiscal decisions, made on the basis of circumstances not even remotely connected with medical care, and made by people not even remotely conversant with the need for medical care or medical facilities.

I am confident there has never been a generation in which spokesmen did not predict that doom and destruction would inevitably follow unless certain trends were reversed or modified. I prayerfully hope that I, and others like me, are as wrong as those earlier prophets were. But I sincerely believe we have reason to fear for the future. I believe the people of our nation are caught up in a philosophy that says problems of any kind are not natural to man, and that they should depend on their government for solutions to all of them.

Unless we can find a way to reverse, or significantly modify, this philosophy, I see little for the children of our children but a subservient society, of which the center of attention might very well be a two-way television screen. Big Brother will be watching.

Finally let me explain that here I have begun a plan to expand the four suggestions I listed in my inaugural address. This is Point Number 2 to resist the trend toward dependence on government for health care. Other points were (1) to show our own competence, (3) to encourage government to be active only in support of private sector and (4) to continue our discussions with government and be helpful in support of those areas where government appropriately has a responsibility.

Ways to Resist the Trend

The salient point of my talk today is that we must devise ways to resist this trend toward dependence on government. I will criticize my talk as I criticize those of our spokesmen who only point with alarm to a dangerous tendency and conclude without making recommendations for a solution.

In my inaugural I pointed out four general directions for action. Throughout the year I will develop these ideas. I beg of you to think in these lines, to be creative and suggest positive action. I would personally welcome your suggestions.

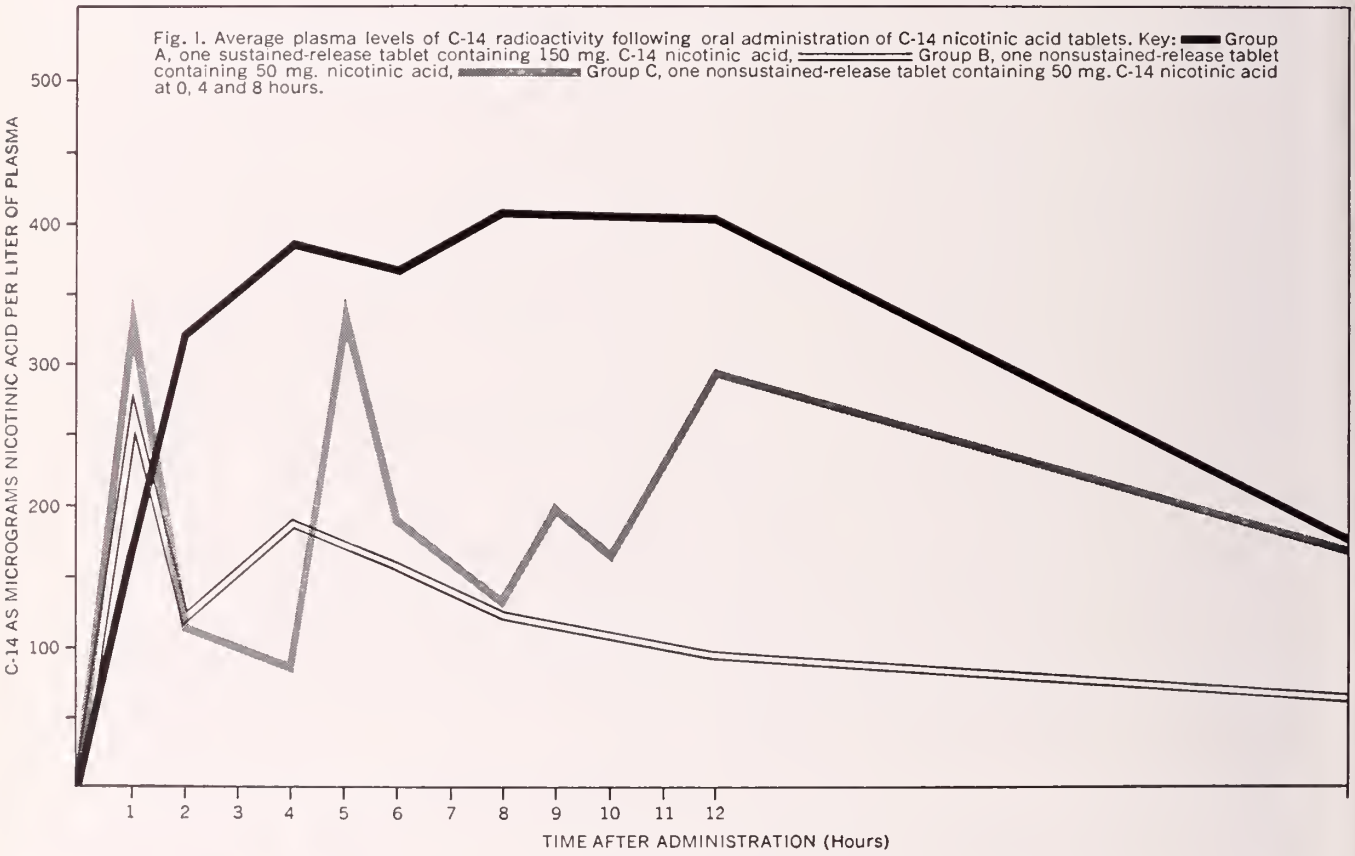
To resist the trend discussed today we must recognize that not only should our patients refrain from overuse of these new health programs because a law has made them more convenient; but we physicians who put their demands into action, must be courageous enough to be selective in what we request for our patients.

Hospitalization which we authorize is tremendously expensive—$100 per day predicted for the near future—50 per cent of the health care bill are drugs that we prescribe—22 per cent of the total bill which together dwarf the costs of physicians services, are examples of areas where we can effect economies by judicious prescribing.

Some of my colleagues are critical of my moderate or judicious approach to our problems. I feel that it is merely the approach of the judge or individual who must see all sides of a question as contrasted with that of the advocate who need concern himself with only one side. Time and circumstances determine which approach is the more effective. In this respect let me close with a story that is appropriate, I feel.

A Protestant minister and a Catholic priest were discussing the differences in their approach to Christianity. The clergymen suggested reconciliation of their differences by saying, "After all, we are both observing God's will—you in your own way and I in His."

Sustained circulatory, respiratory and cerebral stimulation for the



(fewer absent doses by absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

ged and debilitated

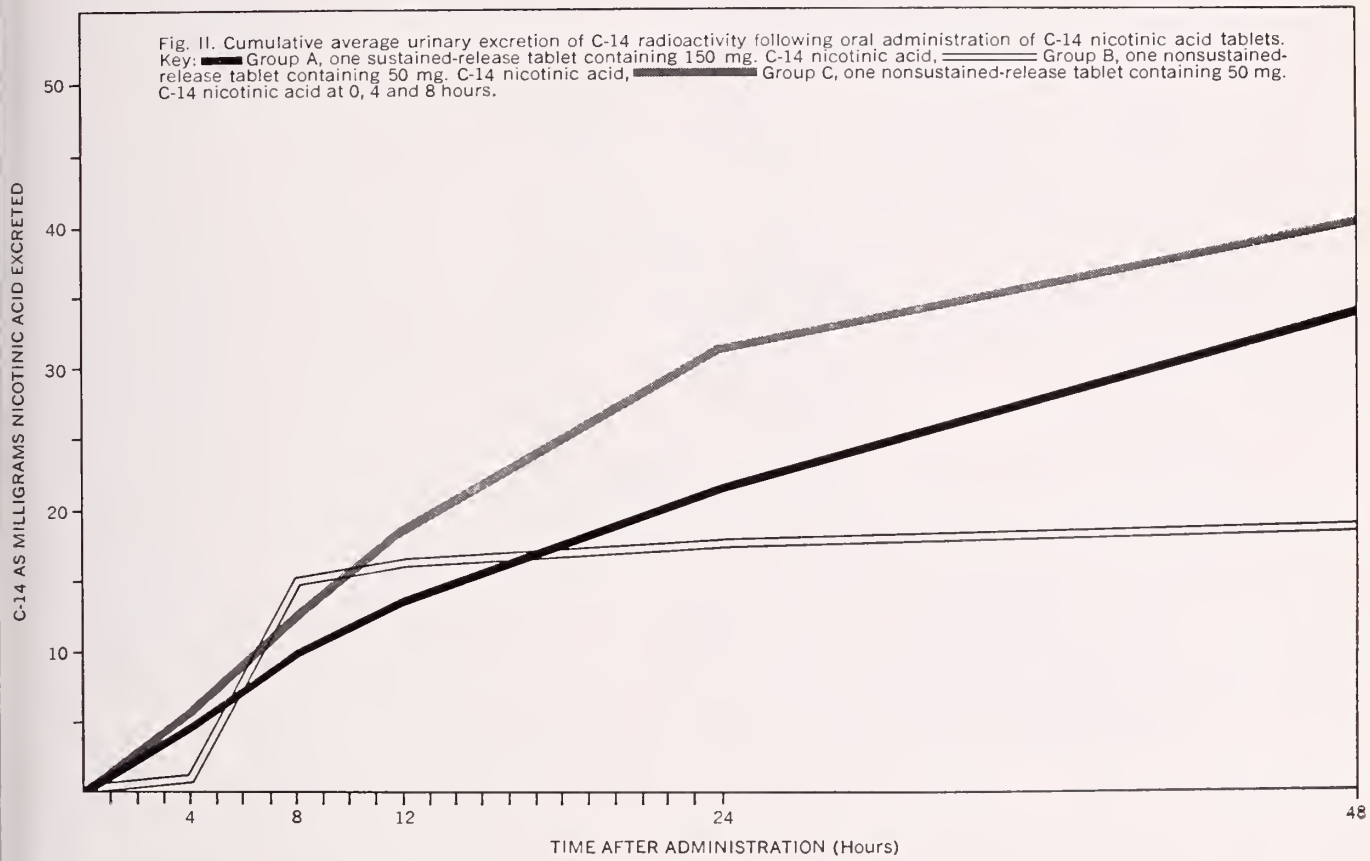


Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▬▬▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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Geroniazol® TT

nicotinic acid 150 mg., pentylenetetrazol 300 mg.
Tempotrol® Time Controlled Tablet

against the usual gram-negative urinary pathogens

Why use five...where one will do?

In a recent 217-patient hospital study,[1] urinary tract infections were treated with a variety of widely prescribed antimicrobial agents including: a sulfonamide (40 patients), chloramphenicol (20 patients), nitrofurantoin (33 patients), nalidixic acid (30 patients), tetracycline (27 patients), colistimethate sodium (22 patients)...and 2 combinations of 5 agents each (45 patients). The 2 combinations were selected to afford maximal theoretical antibacterial coverage against the usual urinary pathogens. They were (1) tetracycline, chloramphenicol, nitrofurantoin, ristocetin and polymyxin B; and (2) tetracycline, chloramphenicol, erythromycin, nitrofurantoin and colistimethate sodium.

This clinical study shows that the two combinations of antibiotics were not superior to some of their single components. The authors point out that antibiotic antagonism often negates theoretical advantages of multiple therapy. Coly-Mycin Injectable (colistimethate sodium) was one of the single components that was shown to be equal to the combinations and eradicated bacteriuria in two-thirds of the patients.

Theoretical choice of multiple antibacterial therapy has been shown to be no more effective than one well-chosen agent which also offers least patient exposure to possible side reactions, toxicities, allergic manifestations and higher drug costs.

1. McCabe, W. R., and Jackson, G. G.: New England J. Med. 272:1037, 1965.

in gram-negative urinary tract infections often the single well-chosen agent

Coly-Mycin® Injectable
(colistimethate sodium)

Indications: Especially indicated for the treatment of severe acute and resistant chronic urinary tract infections due to sensitive strains of gram-negative organisms. Also indicated in respiratory tract, surgical, wound and burn infections and in septicemia due to sensitive organisms. Particularly indicated when any of these infections are caused by sensitive strains of *Pseudomonas aeruginosa.*

Adverse Reactions: Occasional reactions such as circumoral paresthesias, tingling of the extremities, pruritus, vertigo or dizziness may occur. Reduction of dosage may alleviate symptoms. Therapy need not be discontinued, but such patients should be observed with extra care.

Warning: Patients should be cautioned not to drive vehicles or use hazardous machinery while on therapy.

Precautions: In cases of impaired or suspected renal impairment, use with greater caution and reduce dosage in proportion to extent of impairment. Transient elevations of BUN have been reported. As a routine precaution, appropriate blood studies should, therefore, be made during prolonged therapy.

As with all polypeptides, the possibility of muscular weakness, including apnea, due to inadvertent overdosage or normal dosage in the presence of impaired renal function, should not be overlooked. In cases of apnea, medication should be promptly discontinued and assisted respiration given until serum levels fall and normal breathing is restored.

Other antibiotics, such as kanamycin, streptomycin, dihydrostreptomycin, polymyxin, and neomycin, may also have varying neurotoxic or nephrotoxic potential. They should be used with great caution concomitantly with Coly-Mycin Injectable (colistimethate sodium).

For deep intramuscular injection only.

Dosage: By the I.M. route only, in 2 to 4 divided doses ranging from 1.5 to 5 mg./Kg./day (0.7 mg. to 2.3 mg./lb./day). Average adult dose is 2.5 mg./Kg./day (1.1 mg./lb./day). In the presence of bacteremia, septicemia, or other serious infection, greater than average doses may be required; however, maximum daily doses should not exceed 5 mg./Kg. (2.3 mg./lb.) where renal function is normal.

Not recommended against Proteus.

Colistin is also available (as colistin sulfate) in: Coly-Mycin® Pediatric for Oral Suspension (not for systemic use), and Coly-Mycin® Otic with Neomycin and Hydrocortisone.

Full information is available on request.

CI-GP-69-R2

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The Induction of Labor*

Carl B. Hall, M. D.

I believe all of us will agree that the ideal in the practice of obstetrics is spontaneous onset of labor and the least possible interference with its normal progress until its termination. There are many instances, however, in which it becomes necessary to take action to improve matters insofar as the mother and child are concerned. One form of such action has to do with induction of labor.

Indications for induction of labor may be grouped as follows:

(1) *Diseases Peculiar to Pregnancy.*—Some of these are toxemia (pre-eclampsia, eclampsia), placenta praevia (marginal and partial), abruptio placenta, polyhydramnios and erythroblastosis. The keynote of treatment is to stop the gestation before either the mother or the child is in danger.

(2) *Illnesses Associated With Pregnancy.*—Hypertensive cardiovascular disease, nephrosis, pyelonephritis and diabetes.

(3) *Habitual Death of Child After Viability but Before Term.*—This occurs in apparently healthy women. Causes mostly are unknown. Syphilis formerly was a common cause. Chronic nephritis, erythroblastosis and diabetes are responsible in some cases. If the exact time at which viable children usually die is known, labor may be induced a few weeks previously.

(4) *Truly Prolonged Pregnancy (Post-maturity, i. e., Pregnancy of 42 to 43 Weeks' Duration).*—Only if indications are favorable. In most cases in which the patient goes well beyond the calculated date of confinement, she has erred in her menstrual history.

(5) *Elective Induction of Labor.*—To be discussed in detail later in this paper.

Conditions which must prevail before induction of labor is tried are, first, the child must be viable. A baby delivered before the 30th week of gestation has little chance of survival. Second, the condition of the mother must be such that she almost certainly will live through the procedure. Consent of the patient and that of next of kin must be obtained; also, consultation is to be encouraged, first, because human judgment is fallible and, second, to avoid legal entanglement.

The Author

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Prognosis in Induction of Labor

In the induction of labor, what, then, is the prognosis? With today's perfected techniques, induction of labor should be without maternal mortality or morbidity. Mortality for the child varies greatly and depends on the period of pregnancy and the indication which demands intervention. There are many reports in the literature citing cases in which 500 Gm. to 1,000 Gm. premature infants have survived. Good nursing care and the incubator have contributed much toward saving such lives. The child of a sick mother has less chance of survival than the child of a healthy mother.

Presentation

The manner of presentation has much to do with the prognosis in induction of labor. Particularly unfavorable is breech presentation. It is best to secure a cephalic presentation before inducing labor.

Methods of Induction

What, then, are the methods of induction? The two commonly accepted methods of interrupting pregnancy before, at, or after term are (1) hormone induction and (2) rupture of membranes. Hormone induction consists chiefly of administering posterior pituitary extract (Pitocin) hypodermically, intravenously, intranasally or trans-bucally. If given hypodermically, not more than one unit should be given every 30 minutes for six doses, if necessary. Doses of one unit are as effective as those of three to five units in starting labor and are distinctly safer. No injections are given after labor pains begin unless the contractions cease. The pains begin within a few minutes after the injections.

Intravenous drip (the safest way) is carried out as follows: Pituitary oxytricin (Pitocin) is mixed either with normal saline or, preferably, five per cent glucose in a concentration of 0.5

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Submitted to the Publication Committee, April 29, 1966.

cc's. Pitocin to 500 cc's. fluid, or one cc. Pitocin to 1,000 cc's. diluent. The mixture is given at the rate of 25 cc's. for the first half-hour (approximately 12 drops per minute) and 100 cc's. per half-hour thereafter (approximately 50 drops per minute). There follows a gradual physiological increase in uterine contractions maintained only while the solution is being given. Although continuous intravenous injection of posterior pituitary extract (Pitocin) is a physiological form of therapy, it does not increase the success rate over intermittent administration. In the case of some babies, there is pronounced slowing of the heart tone which may persist for a few minutes. Associated with this change is a prolonged, severe contraction of the uterus which can be relieved by stopping the intravenous drip or by slowing the rate of flow. When such a contraction occurs, however, it is wisest to discontinue pituitary extract.

It is absolutely essential that the physician remain with the patient every minute that the pituitary extract is running into the vein, by which is meant from the moment the needle is inserted until the time the baby is born and the placenta delivered.

Rupture of membranes, or amniotomy, the second method of inducing labor, is the most certain and the one most often recommended. It should be performed, however, only in the presence of certain conditions: (1) the cervix must be 50 per cent effaced and partially (at least two cm.) dilated; (2) the head must be the presenting part; and (3) the presenting part must be engaged and easily pushed down below the ischial spines. If these conditions are disregarded the baby may be lost and the mother injured.

Most Common Rupture Technique

What technique of rupture of membranes is most commonly used? To rupture the bag of water, the vulva is prepared as for delivery. A lubricant such as green soap is poured into the vagina. Gloves must be sterile. One or two fingers are inserted, first into the vagina and then into the cervix. The head is displaced slightly upward and the fingers are swung around the entire lower segment to separate the membranes from the uterine wall. After the membranes are loosened, they are ruptured by directing a long Allis forceps, a dressing forceps, a long pair of scissors, or a special perforator along the fingers into the vagina until the cervix is reached with the instrument, guiding the latter through the cervix until the membranes are reached. The instrument either may be forced against the membranes to tear them or it may be pressed up and down against the baby's head, tearing the membranes in its path. If dressing forceps are used, the membranes are grasped and pulled gently, thereby rupturing them. If the patient is having uterine contractions and the bag of waters is to be ruptured, it is best to tear the membranes between pains and not during a contraction, to avoid possible prolapse of the cord when the amniotic fluid gushes forth. The fingers should be kept in the vagina to prevent a sudden gush of fluid, also to wait until the head again descends against the cervix. The baby's heart tones must be auscultated immediately after the membranes are ruptured, just as they must be listened to immediately before and after all inductions of labor.

Recent Tendency Decried

In the past few years, the tendency to rupture the membranes for induction of labor has become widespread. The practice has aroused protest from some obstetricians, decrying such interference with nature. Opponents of artificial rupture contend that the procedure brings about all the evils of dry labor, namely, prolonged and difficult labor, cerebral damage, higher neonatal mortality and more maternal injuries. Impartial analysis reveals, however, that the theoretical dangers of the procedure do not often manifest themselves. In fact, when the method is properly used in the presence of sound indications, labor generally is shorter than normal. The necessity for operative intervention is not increased, with all other risk factors remaining *in status quo*. The bag of waters, therefore, is not as important in the mechanism of labor as was formerly believed, which is not to say that dry labor is without hazard. There must be differentiation between artificial rupture of membranes and spontaneous rupture of the bag of waters before onset of labor. In the latter condition, some abnormality probably is responsible and, rather than the rupture itself, may be the cause of evil consequences which sometimes are observed in dry labor.

Let it be repeated that regardless of the relative innocuousness of artificial rupture of the bag of waters, the procedure properly should be carried out only for a definite indication, only when the head is the presenting part and well engaged or can easily be pushed down below the spines, and only when the cervix is partially effaced and dilated. Otherwise, catastrophe will result. Difficulties may arise if the bag of waters is ruptured simply to hasten a normally progressing labor.

Such is the textbook story of the induction of labor as taught in the medical schools today. Such is the ideal under the best of obstetrical conditions. But it is not the whole story.

Conditions Often Not Ideal

A Sunday School teacher had just narrated to her young students the beautiful Christmas story of Christ's birth. To ascertain what impact the story might have had on the children or what impression it might have made, she asked, ". . . And what does this mean to you?" One child replied, "It means that all babies are not born in hospitals."

We must remember that babies still are being born in the homes in many parts of the country; also, that many hospitals do not have the ideal in personnel and facilities. Thus, babies are being born under many conditions and many labors are being induced under less than ideal situations.

An obstetrical friend of mine reviewed my paper and noted that the absolute necessity of a physician remaining with the patient while pituitary extract is being given was still found to be recommended. He felt that although it was the ideal it was not practical, except when facilities and physician personnel were available such as in large, well staffed institutions. He further stated that there would be no elective induction of labor if that recommendation were strictly adhered to, and I certainly agree that less inductions would be done.

Some of the older methods requiring less supervision and easier to administer still are being used. The time-honored medical induction consisting of castor oil, quinine, and enemas is frequently used in many parts of the country.

The medical induction in conjunction with small doses of Oxytocin intranasally, intramuscularly, or trans-buccally often is used as well as medical induction with rupture of the membranes. The ideal is not always available. An all-out effort must be made to practice the best possible obstetrics based on available personnel and facilities, the recognition of and adherence to indications for induction of labor, and the conditions which should be met before induction is attempted.

From the scarcity of reports on the new medications and procedures, one gains the impression that most physicians practicing obstetrics are satisfied with the present medications and procedures for induction of labor. There is one drug, however, on which a great deal of research has been done and results reported, and the drug is thought to be of value in the induction of labor. The drug is Sparteine sulfate, an alkaloid isolated from scoparius or broom-top. Sparteine sulfate is a pyridine derivative like nicotine and conine; its action is similar. The effect on the central nervous system is slight; here it serves primarily as a depressant. It depresses also the myocardium, and causes bradycardia similar to that caused by quinidine. It has no effect on blood pressure.

In reports that I read, the groups drew the same conclusions about Sparteine sulfate: first, that Sparteine sulfate is an extremely useful drug both for induction and stimulation of labor; second, that its margin of safety appears to be wide and that in proper dosage it is an effective stimulate of uterine contractions; and third, that the same precautions in its use that are standard for Oxytocin should be employed.

Administration.—The agent is administered intramuscularly, and the recommended initial dose for induction is 100 mg., to be followed in one hour as necessary by 75 to 150 mg. Such a regimen minimizes complications both in mother and baby which may result when the customary dose of 150 mg. is used for all patients in doses at intervals of less than one hour and less than two hours after use of Sparteine sulfate and starting of Oxytocin.

Plentl, Friedman and Gray feel that constant observation of the patient during induction or augmentation of labor with Sparteine sulfate is not necessary. It is recommended, however, that the patient be re-evaluated prior to administration of each dose.

Dr. D. A. Sterling Eddie, in a report published in the *British Medical Journal* in 1963, described a simplified intravenous Oxytocin uterine sensitivity test. It was pointed out that since amniotomy to induce labor has been a common practice in modern obstetrics, failure of labor to begin with one or two days of the procedure constitutes a serious problem. Sensitivity of the uterus to a small dose of Oxytocin offers a possible means of forecasting when surgical induction of labor is likely to be successful. The method is to give a small dose of Pitocin (0.5 international units in five cc's. of sterile water) intravenously at the rate of one cc. in one minute. The test, of course, is stopped if uterine contractions start, or after 0.5 units of the infusion of five cc's. is given. It was pointed out that the test can be performed in less than 10 minutes by one person without special equipment. A positive response to 0.5 units or less of Oxytocin was associated with labor occurring within 48 hours of amniotomy in 91 per cent of cases but

if the test was positive to 0.3 units or less, the figure was 100 per cent. The test is particularly accurate when termination of pregnancy is contemplated more than one week before the expected date of delivery. It is in this group of cases that an indication of the likelihood of a rapid response to amniotomy would be of the greatest help in coming to a decision to perform amniotomy or elective Cesarean section.

A relatively new method of administering Oxytocin for the induction of labor which has been studied fairly extensively by many groups, is induction with trans-buccal Oxytocin. In summary of a report published by Newman and Hon, it was noted, first, that trans-buccal administration of Oxytocin for induction of labor was studied in 25 cases. In five cases, trans-buccal and intravenous routes were compared. Second, all patients achieved uterine activity equivalent to that in early labor with trans-buccal Oxytocin, the majority doing so with less than 1,000 international units. Third, the useful dose range was from 100 to 2,000 international units. Doubling the dose every 30 minutes until satisfactory labor ensued appeared to be a safe procedure. Fourth, the latent interval between the initial dose of trans-buccal Oxytocin and onset of labor was half an hour or less in most cases. In all but one case there was a latent interval of less than two hours. Fifth, the trans-buccal administration of Oxytocin was capable of producing uterine activity similar to that produced by physiologic amounts of intravenous Oxytocin. Sixth, the rate of decrease of uterine activity after withdrawal of trans-buccally and intravenously administered Oxytocin appeared to be similar. Seventh, no side effects related to the trans-buccal route of administration either in mother or fetus were noted. Eighth, gross sudden over-dose with trans-buccal Oxytocin is unlikely but over-stimulation can occur. Hence, this method of administration deserves the same close supervision as any other method of induction; Ninth, the results suggest that the trans-buccal route of administering Oxytocin is an effective, acceptable, safe and convenient method of inducing or enhancing labor, provided the patient is carefully supervised.

Much has been written recently about the elective induction of labor, it use and possible abuse, but it is safe to say that the majority of obstetricians today will in some way have the elective induction of labor as part of their practice. The substitution of pharmaceutical agents for the hazardous surgical methods of induction of labor is one of the milestones in obstetric progress. By the use of quinine and pituitary extract, the obstetrician does not burn bridges behind him and, as a result, has broadened his indications for the induction of labor to include cases which do not present the same degree of urgency that surgical methods have demanded. Hence, we note that more than 40 years ago Watson stated, "Some obstetricians advocate routine induction of labor two weeks before calculated term; although not practiced routinely by most physicians, it is apparent that more than a generation of obstetricians have practiced the elective induction of labor."

An early contribution to the induction of labor in women whose only problem was "discouragement and impatience" over being past the expected date of delivery or who were afraid that they might not reach the hospital in time because of distance or previous experience with a rapid labor, was made by Slemons, in 1932. His results were generally satisfactory although not comparable to those noted in the more recent reports.

Mathieu and Holman, also in 1932, reported a series of 750 cases with good results when compared with an equal number of non-induced contemporary cases.

These early reports, however, found no favor among the conservative obstetricians of the period. Kosmak was unapproving. Irving criticized "delivery by appointment" as being a matter of pure convenience for patients and doctors. Cornell was unwilling to accept "streamline obstetrics" for a number of reasons, among which were the risk of inducing labor when the child was immature and an increase in fetal mortality. On the maternal side, he was concerned with uterine infection, postpartum hemorrhage, rupture of the uterus, and laceration of the cervix. Even as late as 1947, Smitz, in the discussion of a paper by Grier, denounced elective induction as "meddlesome obstetrics." One of his criticisms was that the labors were too rapid.

In spite of objection from leaders in the obstetrical field, induction of labor in normal women for convenience, and the idea of a supervised labor and delivery continued to gain acceptance on a wide front. There were three reasons for this: (1) The war years brought a shortage of professional personnel, with increased demands for obstetrical service. In these circumstances, the elective induction of labor in suitable cases gave some semblance of order to the chaotic life of the overworked obstetrician. (2) It was also at this time that the antibiotics significantly changed the prevailing "Hands Off" policy which obstetricians had stressed in the

prevention of puerperal infection. More and more women were examined vaginally in a routine manner during the last months of pregnancy, quite simply and safely with sterile gloves and surgical lubricant. These office examinations were made primarily to evaluate pelvic capacity. Most trained obstetricians abandoned use of the pelvimeter and felt more confident with the information obtained by means of a carefully performed vaginal examination for prognostic value of the forthcoming labor. (3) Change in the training of the physician who took over most of the obstetrical practice in areas of population concentration. Increasing numbers of well qualified specialists were turned out of residency training programs who felt confident that they could select the cases for induction which could be delivered with safety.

As a consequence of these changes in the 1950's, a number of papers were published which dealt with the more determinate form of elective induction. Greenhill already had stated in the 1947 Year Book that elective induction of labor, when performed at the proper time by one who knew how, carried no risk. It is unquestionably true that the uniformly good results in this collective material were due in large measure to the better selection of patients, made possible by the office vaginal examination which revealed the all-important information upon which the success of the induction depends, that is, the so-called "ripe-cervix." The general tenure of obstetric thought now seems to include elective induction in selective cases along with prophylactic low forceps, episiotomy, analgesia and anesthesia as an acceptable supplemental refinement of the trained obstetrician's art. Many advantages are mentioned, varying from trivia such as making timely arrangements for transportation to the prevention of maternal death due to aspiration of stomach contents. But in spite of the generally good results and the alleged advantages to the patient, her family and obstetrician, there remains an undercurrent of doubt about its complete acceptability. Complete acceptance of the elective induction of labor has been difficult to establish because the physician's traditional role of interfering with the course of pathophysiological events only when he can achieve an advantage for his patient remains in doubt. The risk of criticism, although slight, cannot be avoided until it can be shown that the results of elective induction are as good or even better than those in the cases of comparable women whose labor starts spontaneously.

At Sloan Hospital in New York, 1,000 cases over a five-year period from 1955 to 1960 were studied. With these patients selected, limited to first multipara with a term size fetus and vertex presentation, at least partially within the pelvis, and the cervix two cm. or more dilated at the internal os, comparison was made with an equal number of cases selected at random in which labor was induced and delivery accomplished during this same period (1955 to 1960). Several methods of induction were used: (1) most had intravenous Oxytocin followed by amniotomy where there was evidence of satisfactory myometrial activity, (2) in 21 cases the Oxytocin was given intramuscularly and (3) in 155 cases Sparteine sulfate was used as the Oxytocin.

Most of the attendants felt that the use of Oxytocin sensitivity test is important to establish the myometrial readiness for labor before amniotomy is performed, although the added value of the latter is not underestimated.

There were no essential differences between the two groups in the more obvious fetal and maternal morbidity factors. The induced patients, however, showed more rapid labor and while they are interpreted to be the effect of such labors, which include cervical lacerations, postpartum hemorrhage, and depressed infants, it is believed that the rapid labors of the induced group were related to the "ripe-cervix" rather than the induction itself. Since there is evidence that the rapid labor may be harmful to the child, there is justification to electively induce labor in women who show pre-labor cervical dilatation so that control labor may be obtained. In these cases, elective induction has been shown to have prophylactic value.

Niswander and Patterson, in a recent study of elective induction of labor, felt that elective induction distinctly was a hazard to the fetus. Results of their study of 2,862 consecutive cases of induced labor at Buffalo General and Buffalo Children's Hospitals indicated that elective induction, when it includes artificial rupture of the membranes, significantly increases the hazards of labor, also that increased risk can be found both in terms of fetal mortality and morbidity. The chief complications accounting for the added toll are prematurity, hyaline membrane disease and cord prolapse. Induction is performed in many cases in which generally accepted contraindications such as twin pregnancy and breech presentation are present, although not usually recognized.

Using this report as a starting point, the *OB-GYN Observer* sought the opinions of seven leading clinicians around the country on various aspects of the problem of elective induction. The observers consulted were Barter, George Washington University School of Medicine;

Davis, University of Chicago; Kaiser, University of Utah Medical School; Mastroianni, University of California Medical School; McLane, New York Hospital, Cornell Medical Center; Nesbitt, State University of New York Upstate Medical Center, and Noyes, Vanderbilt University School of Medicine.

Without exception, these men expressed the opinion that elective induction of labor does have a place but that the place is limited. Over and over again the statement that "the convenience of the physician should not be a consideration," was made.

Typical of the views offered on elective induction was that of Davis, who stated, "The patient who has a history of rapid labors and precipitate deliveries, may have an indication for induction, as might the multigravida who lives a long distance from the hospital or in an area where travel is difficult."

While agreeing that geographical remoteness from the hospital may constitute an indication for elective induction, Nesbitt added this somewhat unorthodox suggestion: "In choosing between two unfortunate circumstances, an unsupervised spontaneous delivery at home might constitute less risk than an ill-timed, ill-conceived, traumatic intervention in an unfavorable obstetric situation."

A question posed to each of the physicians as to what conditions should be fulfilled before undertaking elective induction, brought this representative response from Noyes: "The patient must be at term and carrying a single term size infant; she should be multiparous with vertex presenting and engaged or engagable. Her uterus should be irritable with the cervix soft, effaced, pointing in the axis of the vagina and dilated sufficiently to admit two or more fingers. Of great importance, the patient and her husband and, if possible, her family, should understand and eagerly accept the idea. I also believe that a Board qualified obstetrician and gynecologist should be available as a consultant in a well-staffed hospital which is uncrowded at the time of the procedure."

On the question of method of induction, Kaiser expressed the consensus when he outlined his preferred technique as follows: "Artificial rupture of the membranes which may or may not be followed by the intravenous administration of dilute Oxytocin by constant infusion, if the patient fails to fall into spontaneous labor within two hours."

Kaiser incidentally stresses that this technique is applicable only if criteria such as those outlined by Noyes are met. While this with some variation in timing was the most common approach, it was by no means the unanimous choice of those interviewed. McLane, for example, generally avoided the use of Oxytocics. He told the *OB-GYN Observer*, "The only elective method is artificial rupture of the membranes. If the patient does not go into labor after this procedure, I would have to assume that the conditions have not been met before induction was attempted. I have done many inductions under these conditions and I would say offhand that not more than three have necessitated employment of some other technique subsequent to membrane rupture."

Mastroianni, on the other hand, asserted, "Under no circumstances is it justifiable to rupture the membranes for elective induction until labor has clearly been established by Oxytocin stimulation. Once the membranes are ruptured an avenue for infection exists and delivery should be accomplished within a reasonable period of time. I therefore would induce labor with an intravenous Oxytocin infusion initially; after labor is clearly established, it is reasonable to rupture the membranes provided the presenting part has descended into the pelvis."

For his part, Nesbitt seeks to avoid both amniotomy and Oxytocin infusion as methods for initiating uterine contractions. When possible he does this by stripping the membranes once or even twice. Only if this fails to start labor does he perform amniotomy. Then he waits six to eight hours before instituting an Oxytocin drip. He noted that, "The last form of treatment will not be necessary in the majority of the cases before administering an Oxytocin. It is my policy to obtain x-ray pelvimetry to be assured of a normal pelvis and to confirm engagement or near engagement of the fetal vertex, if there are any doubts about these clinical assessments."

The comparative frequency of cord prolapse in Niswander's series brought this comment from Barter: "When amniotomy is carried out with the patient in Trendelenberg position, it is my feeling that prolapse of the cord will not occur. If the cord does prolapse, it merely signifies that the patient already had an occult prolapse and that the cord would prolapse when the patient's membrane ruptured spontaneously, and in those circumstances we felt that it was much better to make the diagnosis of an occult prolapse of the cord by palpation and to avoid rupture of the membrane."

The frequent occurrence of prematurity in the Buffalo study also drew comment from the discussants. Typical was that of Mastroianni: "Be-

cause fetal size is very difficult to evaluate at best, induction should be deferred when there is any doubt about fetal maturity. The risk of prematurity and therefore of hyaline membrane disease can certainly be reduced by careful selection of patients for elective induction. We have proved to ourselves that it is possible to deliver patients electively without materially increasing the risk of prematurity or hyaline membrane disease among patients having elective repeat Cesarean section. Excluding patients who entered into labor in the past two years, we have not delivered a single infant with a birth weight of under 2,500 Gm. by elective section at Harbor General Hospital." As a final question, the obstetricians interviewed were asked whether they believed elective induction was being overdone in their area. The majority did not believe so, although in several cases they limited their replies to the institutions with which they were affiliated. There were two exceptions, however, thus Doctor Davis said: "There is little doubt that elective induction is overdone in the Chicago area, although there has been a greater tendency to a more careful selection of patients and better control of the procedure." McLane's view was even more critical: "It is my feeling that elective induction of labor is not only being overdone in the area in which I live, New York, but all over the country. Because it is being overdone and because a lot of patients are being induced that should not, the procedure gets blamed for complications and difficulties that it really should not be blamed for." This note of defense for elective induction when done on the basis of sound clinical judgment was echoed by Barter when he concluded, "It is impossible for me to believe that a well conducted elective induction compromises the baby any more than normally conducted labor. In an ill advised induction where labor does not occur or where labor is prolonged, I am sure that the baby must be subjected to the same hazards that would be precipitated by any prolonged or otherwise unfavorable labor. Induction of labor when all of the proper criteria have been fulfilled actually represents a positive or dynamic concept of obstetrics."

It is apparent that there is quite a divergence of opinion as to the need for the induction of labor purely based on an elective approach by the obstetrician.

There is one other hazard which was reported in the June 1964 issue of *Medical Economics* which had to do with "the abandonment of the OB patient, and your liability to those patients that you electively induce." This is the lawyer's way of charging a physician with not being at the bedside during a delivery, with induced labor as a common reason for his not being there. It may be convenient but it can turn into a medicolegal headache if it forces more patients into labor than the physician can properly handle at one time. In the case reported, the obstetrician gave a patient an injection of an Oxytocin drug at 11 A.M., and gave a second patient an injection at 12:30 P.M. While he was busy delivering the first patient, the second one started to deliver and had to be assisted by an intern. Dissatisfied by the episiotomy incision, the second patient sued the Ob-Gyn man for abandonment. She collected $4,000. Too heavy a patient load will land physicians doing obstetrical work into the medicolegal field. This is particularly noted when obstetricians find themselves delivering patients in several hospitals.

Recently I talked with a physician's wife who, while in Philadelphia some years ago, was going to an obstetrician for her pregnancy. During one of her appointments she overheard the obstetrician talking on the telephone to another hospital across town. He stated that he could care for a patient in labor at both hospitals. She asked him how it was possible to care for both patients in labor at the same time. The obstetrician responded, "Oh, I will simply slow one down and speed the other one up." The physician's wife admitted that she had some moments of doubt as to whether she would receive adequate care at the time of her delivery. That certainly is the practice of obstetrics "for the convenience of the physician," and I am sure that in that type of approach there would be many hazards introduced which certainly are unnecessary.

One obstetrician states, "Since there is ample evidence of the safety of properly elective induced labor, and since the advantages to the patient are obvious, I think it is high time we shed our shame over preferring to practice obstetrics in the daytime."

That, then, is the induction of labor or at least part of the story.

I return to the opening statement of this paper. I believe all of us will agree that the ideal in the practice of obstetrics is spontaneous onset of labor and the least possible interference with the normal progress of that labor to its termination. Therefore, it is necessary to remember that in all fields of medicine there are many ways to accomplish the job at hand, and each case must be individualized and procedures used which will best accomplish the job in that particular case at that particular time and place.

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Enzyme Determinations in Myocardial Infarction*

James H. Getzen, M. D., and Alfred K. Pfister, M. D.

During the past 50 years little has been added to the history and the physical examination of patients with myocardial infarction. The laboratory, therefore, has been called upon for help in establishing a more precise diagnosis of the disease.

In cases of myocardial infarction, laboratory findings have been of help in detecting recent myocardial injury, especially in those cases in which abnormal electrocardiograms result from conduction defect or some other established abnormality of the tracing.

Help from the Laboratory

The earliest laboratory findings were elevation of the white blood count and of the sedimentation rate.[1] Other laboratory tests were studied, for example, the C-reactive protein test, in cases of myocardial damage. These determinations ultimately were to be classified as nonspecific in nature. Elevation of the sedimentation rate occurs between the first and second day and can remain elevated for as long as from four to six weeks or more after infarction. Increase in the white cell count, which develops the first day, gradually will return to normal levels within the first week.

The C-reactive protein becomes positive at approximately the same point at which elevation of the sedimentation rate occurs but the former returns to normal level within two to three weeks.[2]

La Due, Wrobleskie and Karmen,[3] in 1954, reported 50 cases of myocardial infarction in which alteration of the enzyme SGOT occurred. Since the time of their original report, multiple determinations have been made in cases of myocardial infarction and this laboratory procedure now is acceptable as an aid in the diagnosis of acute myocardial damage.

What Is An Enzyme?

An enzyme is defined as "a catalytic substance formed by all living cells and which has a specific action in promoting a cellular change.[4]" Certain amounts of these enzymes may be detected in the blood system. Approximately 50 enzymes have been identified and isolated, thus far. Practically all 50 have been studied in the observation of patients who have had myocardial infarctions, and may be measured in varying amounts at specific times following cellular injury. These elevations have developed either by liberation from the damaged cell or by decrease in elimination from the plasma compartment.

The most frequently determined enzymes are those listed in Table 1.

Table 1

1. Glutamic pyruvic transaminase.
2. Glutamic oxalacetic transaminase.
3. Lactic dehydrogenase.
4. 2-hydroxybutyric dehydrogenase.
5. Creatine phosphokinase.
6. Aldolase.
7. Isocitric dehydrogenase.

In our laboratory, the SGOT (serum glutamic oxalacetic transaminase), LDH (lactic acid dehydrogenase) and CPK (creatine phosphokinase) are determined in cases of individuals admitted to hospital with possible myocardial infarction.

Serum Glutamic Oxalacetic Transaminase

The SGOT has been the enzyme which offered the best correlation with myocardial infarction.[5,6] It recently has been suggested, however, that a combination of enzyme determination may be more helpful.[7] The enzyme SGOT is concerned with transference of amino acid groups from one molecule to another.

During the first few days of acute myocardial infarction, this particular enzyme becomes elevated, by intracellular enzyme release, to the extracellular compartment. The enzyme concentration usually is expressed in units of micromols or millimols of substrate reduced or the amount of product of the hydrolysis per unit time under a specific condition.[8] The normal level of SGOT ranges from eight units to 40.

A typical example of serial SGOT determinations in cases of myocardial infarction may be

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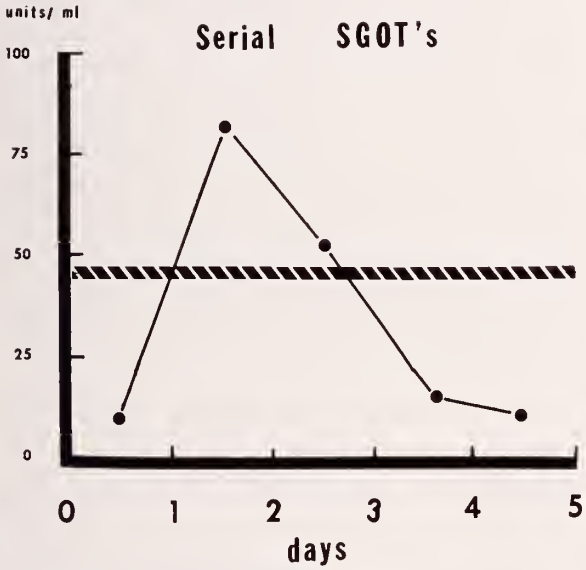
Submitted to the Publication Committee, March 16, 1966.

observed in Graph 1. The rise occurs as early as the sixth hour after myocardial infarction, reaches a peak in from 24 to 48 hours, and returns to normal range after the fourth to the seventh day. The increase in SGOT has been reported to be diagnostic in 92.3 per cent of cases, as compared with the electrocardiogram, which has been diagnostic in approximately 82 per cent. [9, 10] When enzyme studies are done properly, elevation of the SGOT will occur in 100 per cent of cases.

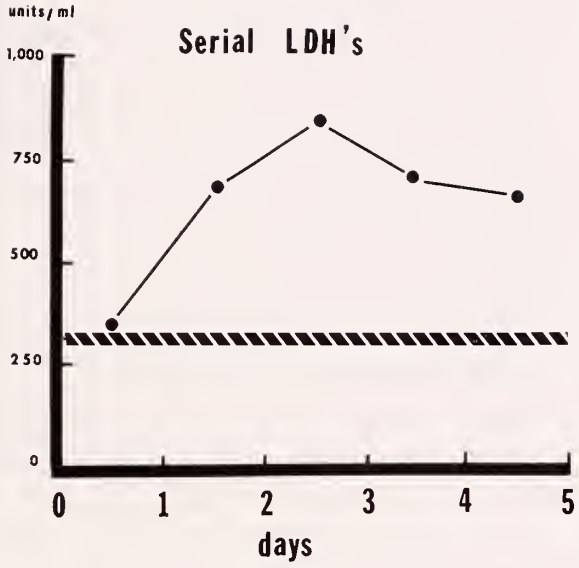


Graph 1

Since reporting the original description of SGOT alterations in myocardial infarction, the enzyme has been found elevated in the presence of other conditions, as a result of damage to other tissue. Types of tissue damage producing elevation of SGOT levels are skeletal muscle, liver, kidneys and brain, as well as the myocardium.[1, 5, 11] The same enzyme is elevated in certain myocardiopathies, either toxic or infectious hepatitis, in metastatic carcinoma of the liver, and in hemolytic crises. Certain drugs will elevate the SGOT such as anabolic steroids, salicylates, coumadin and streptomycin, all of which seem to have some effect on liver function.[8,12] Digitalis, quinidine, morphine, demerol and codeine do not elevate the SGOT.[13]

Lactic Acid Dehydrogenase

The most exciting enzymatic study of the past few years has been related to the enzyme LDH (lactic acid dehydrogenase). This enzyme catalyzes the reduction of pyruvic acid to lactic acid in the presence of reduced phosphopyridine nucleotide. The normal range of this enzyme is from 100 to 350 units and has a curve similar to the SGOT.



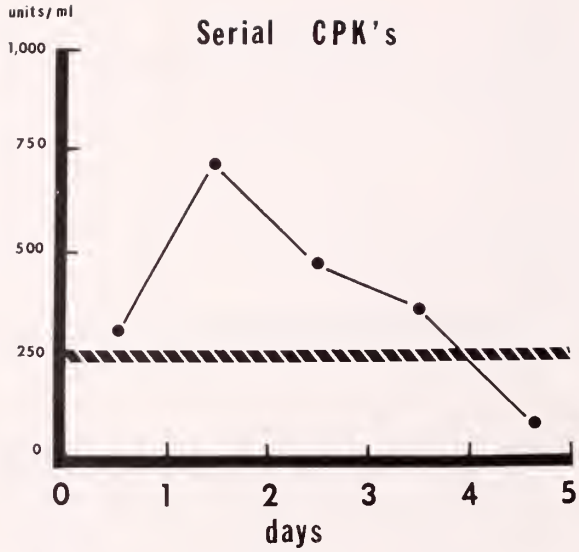
Graph 2

Elevation of the LDH activity in myocardial infarction is slower than that of SGOT, the rise beginning approximately the first 12 hours, reaching a peak around the third to the fifth day and remaining elevated for from 14 to 18 days (Graph 2).

Further study of the lactic acid dehydrogenase produced evidence that this enzyme actually is made up of several different enzymes. [11, 14, 15, 16] The various portions of the LDH separate electrophoretically into isozymes labelled LDH I, II, III, IV and V. When these isozyme patterns are compared with the globulin separation obtained by serum electrophoresis, they are labelled Alpha I, Alpha II, Beta, and Gamma. LDH I migrates as Alpha I, LDH II migrates as Alpha II, LDH III as Beta, and LDH IV and V migrate as Gamma. After the total LDH enzyme is determined, percentage of the various fractions is separated electrophoretically.

In some cases of myocardial infarction, there is a normal total serum LDH level but there can be an abnormal electrophoretic separation of the LDH enzyme. At times, it may be difficult to differentiate LDH elevations, due to myocardial infarction with congestive failure or to hepatic congestion or pulmonary emboli. The distribution of LDH isozymes in hepatic congestion or inflammation shows an increase in LDH I, whereas in myocardial infarction an increase in LDH IV and V is noted. [11, 14]

Strandjord[20] pointed out a simpler method than electrophoresis for separating the LDH isozymes. It is performed by heating the serum to determine the heat labile and heat stabile portions of the LDH. If the serum of a myocardial infarc-



Graph 3

tion patient is heated, only slight reduction in the total LDH determination will result, as opposed to rather marked reduction of total LDH in patients with hepatic disease. Therefore, LDH IV and V are characteristically heat labile.

Creatine Phosphokinase

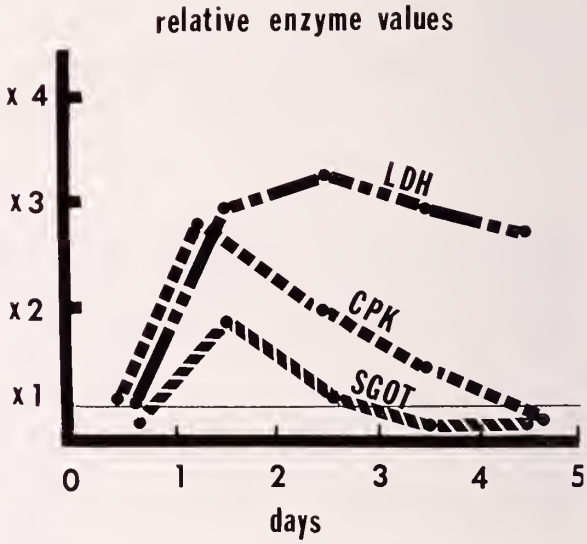
The last major enzyme to be determined in our laboratory is the creatine phosphokinase. As an enzyme, it catalyzes the transformation of creatine with ATP to ADP plus creatine phosphate. Normal range is 0 to 12 (determination of CPK is by the use of reagent from Sigma Chemical Company, and units are expressed as Sigma units. Hess et al,[17] in 1964, reported their use of creatine phosphokinase in cases of myocardial infarction. Their determinations and those of others[18] produced curves similar to ours (Graph 3). The pattern is similar to that of SGOT, with a rise in the first 6 to 12 hours and, by the third day, a return to approximately normal levels. One advantage of this enzyme is that only minimal damage to the myocardium is necessary to produce an elevation. The cardiac and skeletal muscle was quite high in the enzyme while the liver and lung produced very little, if any, elevation in the CPK. It is, therefore, a useful enzyme for detection of myocardial infarction with congestive failure or in the exclusion of pulmonary emboli.

Graph 4 depicts the relative values of the three enzymes determined (SGOT, CPK and LDH) in acute myocardial infarction. This illustrates the relative elevations of the enzymes over their normal level, indicating the LDH may be slightly more sensitive than the SGOT and CPK, especially after the second day.

Summary

Detection of serum enzymes in clinical states associated with cellular injury has assumed its place in medicine. There still is a wide range of evaluations in this field that must be clarified.

Precise evidence of myocardial damage may be determined by detection of enzyme abnormalities. It appears that the greatest degree or the greatest extent of use would result from the determination of lactic acid dehydrogenase, its various components measured either by heat fractionation or by isozyme determinations and the creatine phosphokinase.



Graph 4

When enzyme determinations are used intelligently in association with clinical evaluation, the diagnosis of myocardial damage should and will be made with less difficulty.

A list of references may be obtained by writing to The Journal.

MOLECULAR REMODELING—

laboratory exercise or clinical necessity?

More than twenty-five years have passed since the discovery of the diuretic activity of sulfanilamide started pharmacologists on a succession of molecular remodelings to find the ideal diuretic.

Diuresis—a sought-after clinical effect from an unwanted side effect

It started in 1937 when a clinician reported that the administration of a sulfonamide was sometimes accompanied by an unexplainable side effect—metabolic acidosis.[1] Three years later the side effect was explained. The sulfonamide radical of sulfanilamide inhibited carbonic anhydrase,[2] the enzyme responsible for converting carbon dioxide and water to hydrogen ions and bicarbonate ions.

Later, other investigators showed by dog experiments that metabolic acidosis probably resulted when the inhibition of carbonic anhydrase upset the exchange of hydrogen and sodium ions, causing increased excretion of sodium as the bicarbonate.[3]

It was twelve long years after the first report of the unexplainable side effect (metabolic acidosis) that it was finally shown that large doses of sulfanilamide administered to edematous patients were indeed capable of promoting diuresis.[4] However, the possibility of toxic effects from its prolonged use and its relatively weak diuretic action made it impractical for clinical use as a diuretic.[5]

Because the inhibition of carbonic anhydrase seemed to be the key to effective diuresis, investigators began to look for more potent enzyme inhibitors —in the hopes that they would be more effective diuretics.

The most important of these early compounds, acetazolamide, enjoyed several years of fairly wide clinical use.

Its carbonic anhydrase inhibitory activity was several hundred times greater than that of sulfanilamide.[6] The increase in inhibitory activity, however, increased not only the excretion of sodium and bicarbonate ions, but also the excretion of potassium.[7] And, like its predecessor, acetazolamide precipitated mild acidosis. Its prolonged use could result in hypokalemic acidosis.[7]

The 'thiazides'—an answer to the metabolic acidosis caused by carbonic anhydrase inhibition

Despite the fact that the sulfonamide group appeared to be responsible for carbonic anhydrase inhibition which in turn appeared to be responsible for diuresis, investigators began to synthesize compounds with structural alterations to the sulfonamide group.

The first major breakthrough came with the synthesis of chlorothiazide. Altering the sulfonamide group did indeed alter the ability of chlorothiazide to inhibit carbonic anhydrase—it was only 1/10th as potent as acetazolamide in inhibiting the enzyme.[8] Despite the drop in inhibitory potency, however, chlorothiazide proved to be an effective diuretic—an observation that led to the conclusion that its diuretic action was due to some mechanism other than its action on carbonic anhydrase.[9,10]

For effective diuresis, chlorothiazide was administered in daily dosages ranging from 250 to 2000 mg.[11] It increased the excretion of sodium and chloride; and, to a lesser extent, potassium and bicarbonate.[11] The excretion of potassium appeared to be maximal at higher dose levels at which, theoretically, the carbonic anhydrase inhibitory effect is more active.[11] Its prolonged use, therefore, could sometimes result in metabolic hypokalemic, hypochloremic alkalosis.[7]

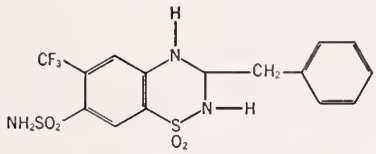
Naturetin—effective diuresis with more favorable electrolyte balance

Other thiazides followed—with improvements being aimed at two particular areas: 1. attempts to increase diuretic action in relation to the milligram potency of the drug, and 2. attempts at a more favorable sodium/potassium ratio in the urine, i.e., to decrease the excretion of potassium while maintaining the excretion of sodium.[12]

One of these, Naturetin, Squibb Bendroflumethiazide, has made advances on both these points. "By adding a 3-benzyl radical to hydroflumethiazide a rather dramatic reduction in dose range is accomplished. With this drug, effective sodium excretion is obtained with doses between 2.5 and 10 mg., which is a 200 to 1 ratio as compared to chlorothiazide..."[13]

Moreover, due probably to its virtual lack of carbonic anhydrase inhibition, Naturetin (bendroflumethiazide) has been shown to cause less potassium and bicarbonate loss and less alteration in urinary pH than either chlorothiazide or hydrochlorothiazide.

Naturetin is outstandingly effective not only in establishing, but also in maintaining, excretion of retained fluid in edematous patients. And its duration of action is sufficiently prolonged to allow a single daily administration in most patients. Naturetin is also an effective antihypertensive agent.



Contraindications: Severe renal impairment; previous hypersensitivity.

Warning: Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting, or G.I. bleeding occur.

Precautions: The dosage of ganglionic blocking agents, veratrum, or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Electrolyte disturbances are possible in cirrhotic or digitalized patients.

Side Effects: Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, and rashes may occur.

Supplied: Naturetin (Squibb Bendroflumethiazide) 5 mg. and 2.5 mg. tablets. Also available Naturetin c̄ K [Squibb Bendroflumethiazide (5 or 2.5 mg.) with Potassium Chloride (500 mg.)]. For full information, see Product Brief.

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A message from . . .

The President

WATCH FOR THE GOBLINS—AND A HAPPY, HAPPY THANKSGIVING

THE Goblins of Medicare go on and on . . . about the $50 deductible - - it must be incurred if an assignment is taken *but* it must be paid if direct billing is decided upon. The reason: an incurred bill cannot be paid to the Medicare recipient or the Medicare recipient can only be reimbursed on cash paid. Direct billing is still the billing recommended.

I attended the Kentucky Medical Association meeting - - nice, new friends and a special thanks to Charles Bryant and now Immediate Past President Everett Baker. New thoughts but the same old problems as we have.

Central West Virginia and Buckhannon had me in - - nice friendly meeting and the trip made most enjoyable by Kathleen and Jake Huffman's hospitality. Then we (Robert Byrd, my trusted friend, and I) went to the Rural Health Conference at Jackson's Mill. Jackson's Mill is a beautiful area at this time of the year, as are all the hills throughout West Virginia.

The Rural Health Conference was a *real success* and many thanks to Martha Coyner for all her fine efforts and to all who came to break all previous attendance records. And, many, many thanks to Kathleen and Jake for serving breakfast to Robert and me before directing and accompanying us to the Conference.

After the Rural Health Conference another pleasant drive through the "painted" hills of West Virginia and into Pennsylvania to the Greater Pittsburgh Airport and then on to the AMA Meeting on Quackery in Chicago - - good, but not for reporting here.

At this writing I'm at the Pennsylvania Medical Meeting and many thanks to Bill West, Ev McClenahan and my personal host, Louis Jones, of Wilkes-Barre. So friendly and so nice to meet many notables and to be hosted so royally - - and the same problems here as at home and in Kentucky.

Have You Joined WESPAC? If not, *please join now* - - so much legislation confronts us now and so much more to come and *we need friends. Monies aren't squandered* and *we need help now* - - nothing comes for nothing so let's *pay our own way for a change!*

The Centennial - - received many nice things and need much more; please continue to send the material in so it can be properly catalogued. Many thanks.

Happy, Happy Thanksgiving to you all.

RICHARD E. FLOOD, M. D., *President*

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EDITORIALS

OUR CHANGING TIMES

In a recent issue of *The AMA News* there appeared a report of a study made by the Citizens Commission on Graduate Medical Education, with recommendations which could produce sweeping changes in our concepts of graduate medical education. The absolute need for adapting the program to the changes in scientific and social structures was stressed by the warning that government would take over such responsibility if the medical profession failed to sponsor the needed changes.

Perhaps the most radical step recommended is the elimination of internships and creating instead a comprehensive, single period of training in medicine, psychiatry, pediatrics, medical gynecology and preventive medicine, planned as a uniform entity. A simple rotation of services is not sufficient to produce a comprehensive training program.

The Commission recommended that the primary physician have some experience in handling emergency surgical problems. This should be true for all specialties. The primary functional physician should be taught a new body of knowledge which will produce a comprehensive and continuing health care.

The Commission recommended the creation of a permanent Commission on Graduate Medical Education to plan, coordinate and review the standards required for primary comprehensive care. The specialty boards and societies which limit their membership to particular segments of medical practice are not qualified to assume responsibility for the entire range of graduate medical education.

This discussion brings to mind the long-standing general shortage of intern and resident physicians in our hospitals, except possibly for those hospitals associated with teaching centers. The shortage in house staff, together with the inability for the overworked physician in private practice to handle all emergency calls, has caused another problem—the staffing of the emergency rooms in our larger hospitals located in urban centers whose population areas produce a large number of admissions to hospital emergency rooms. We have 14 hospitals of plus 200-bed capacity located in areas large enough to produce a sizable emergency patient load. According to present information the staffing of these 14 emergency rooms comes from a resident staff short in numbers, from staff members who happen to be in the hospital, or by staff members who are assigned a 12-hour nightly stay in the hospital on a rotating basis, and responsible for emergency room calls.

As of July 1, 1966, one of our larger hospitals (St. Mary's of Huntington) has employed the

full-time services of four general practitioners who devote full time to emergency room service, working a 12-hour shift for five days and off for five days. In July, 1533 patients were seen and 168 were admitted to the hospital for observation and further treatment; in August, 1663 were seen in the emergency room and 258 admitted to the hospital. There has been general acceptance and commendation from the hospital, the staff and their medical colleagues—only the patients of these men who had to find new family doctors have complained of the system. Medically speaking, the program is highly successful and, economically, it has served the hospital and emergency medical staff to advantage.

This experience might well lead to the adoption of similar plans in our larger city hospitals, and the primary comprehensive services rendered certainly tend to accentuate the recommendations of the Graduate Medical Study Commission.

THE SIGNIFICANCE OF ARCUS SENILIS

Arcus senilis is a common clinical finding, but its significance is still not entirely clear. It may be defined as an opacity of the peripheral cornea due to the deposition of cholesterol, phospholipids and neutral fat in the surface membrane and stroma of the cornea. It is thought that the fat content of arcus senilis is derived from the blood, which, of course, suggests an analogy with atherosclerosis. On this account it is believed by some that the occurrence of an arcus senilis might be associated with the presence of atherosclerosis. Recently two interesting studies have been reported on this condition.

McAndrew and Ogston[1] compared the incidence of arcus senilis in middle-aged postcardiac infarction patients and age-matched male subjects without clinical or electrocardiographic evidence of occlusive vascular disease. They reported that the incidence of arcus senilis in male patients aged 40 to 69 who had suffered a myocardial infarction did not differ significantly from control patients in the same age group. They reported further that patients who had suffered a myocardial infarction and who had an arcus senilis did not differ from those without an arcus in respect to serum cholesterol, blood pressure, or body build.

These workers also reported that all patients with serum-cholesterol over 350 mg/100 ml had an arcus senilis. They observed, furthermore, a progressive rise in incidence with advancing years; this observation would not be unexpected.

Rifkind[2] obtained somewhat different results. He reported the incidence of arcus senilis in ischemic heart disease and its relation to serum-lipids, and also the relation between arcus senilis and serum-lipids in the normal population. The studies were made on a large healthy male and female Scottish population, and in male subjects with myocardial infarction. The subjects ranged in age between 30 and 69 years.

He reported a significantly increased incidence of arcus senilis in the younger males who had suffered myocardial infarction. Serum-cholesterol levels were significantly higher in normal males with arcus senilis than in those without, and the severity of arcus senilis was related to serum-cholesterol levels.

It appears from these two excellent studies that agreement is not yet complete. In point of fact, earlier workers have also reported divergent findings. Obviously still further studies should be made, especially since there is at present such a lively interest in cholesterol metabolism.

There is apparently a consensus that arcus senilis is a sign of rather advanced age; indeed the term senilis suggests this. But this is not necessarily true, for the condition may occur in relatively young people; for example, Rifkind found an incidence of 14 per cent in people whose age ranged from 30 to 39 years. Because the condition may be found in young individuals Rifkind insists that the term arcus senilis is unsatisfactory. He favors a more descriptive term, such as "arcus lipoides cornea" or "corneal arcus." The latter one would more likely be accepted because of greater simplicity. On the other hand, the term arcus senilis is so firmly entrenched in the literature that it will indeed be difficult to replace it by any other term.

1. McAndrew, G. M., and D. Ogston, Brit. Med. Journal, 1:425 (Feb. 13) 1965.
2. Rifkind, B. M., Lancet, 1:312 (Feb. 6) 1965.

Rx Generic—False Economy

Regardless of the criticisms that fall our lot, it is the physician's responsibility to prescribe those medications which will most effectively aid in the recovery of the patient. This responsibility cannot be delegated to any politician, government official, or pharmacist. If he can minimize the injury to the patient's pocketbook, this is desirable. However, it is false economy to prescribe a drug under its generic name if there is reasonable doubt about the clinical acceptability and effectiveness of the brand that will then be dispensed by the pharmacist.—William M. Straight, M. D., in *Bulletin* of Dade County (Fla.) Medical Association.

GENERAL NEWS

19th Annual Rural Health Conference Sets Attendance Record

The 19th Annual Rural Health Conference, sponsored by the West Virginia State Medical Association, drew a record attendance of 396 persons at the State 4-H Camp at Jackson's Mill on October 6.

The attendance figure exceeded by four the previous record of 392 set in 1965. Prior to 1965, the record was 303, in 1964.

The Conference is conducted each year under the auspices of the Association's Rural Health Committee in cooperation with the West Virginia Home Demonstration Council, the West Virginia Farm Bureau, the State Health Department and the Cooperative Extension Service of West Virginia University.

Doctor Coyner Presiding Officer

The presiding officer of the Conference was Dr. Martha Jane Coyner of Harrisville, Chairman of the Rural Health Committee. Dr. Stanley H. Martin of Buckhannon, President of West Virginia Wesleyan College, gave the invocation.

Dr. Richard E. Flood of Weirton, President of the West Virginia State Medical Association, gave the welcoming address.

Keynote Address

Dr. Bond L. Bible of Chicago, Secretary of the Council on Rural Health of the American Medical Association, was scheduled to present the keynote address entitled "Toward Excellence in Country Living." However, due to the illness of his wife, Doctor Bible was forced to cancel his appearance, and his paper was read by Dr. William Carlyon of Chicago, a new member of the AMA staff.

Other Morning Speakers

Besides Doctor Carlyon, other speakers at the morning session included Mr. Norman H. Davis, Director of Medical Programs for the Sears-Roebuck Foundation; and Dr. Robert R. Huntley, Assistant Professor of Preventive Medicine at the University of North Carolina School of Medicine.

Mr. Davis used color slides to illustrate his talk on "The Community Self-Help Plan." Doctor Huntley described "The Comprehensive Concept of Community Health Services."

Panel Discussion on 'Medicare'

Following a luncheon sponsored by the State Medical Association, the afternoon session was devoted to a panel discussion on Medicare, with eight experts in various aspects of the program participating.

Dr. N. H. Dyer, State Director of Health, served as moderator. Panelists were:

Dr. B. B. Richmond, Medical Director of the State Health Department's Health Insurance Benefits Unit; Mr. Harry Parker, Director of Administration for the Health Insurance Benefits Unit; Mr. Robert Campbell

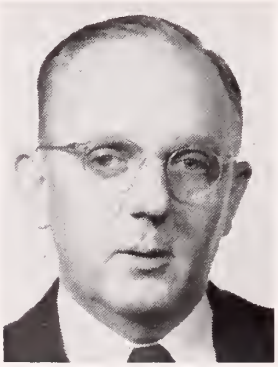
In picture at left, Dr. Martha Jane Coyner of Harrisville, is shown with two of the guest speakers at the Rural Health Conference. In foreground is Mr. Norman H. Davis, Director of Medical Programs for the Sears-Roebuck Foundation. At Doctor Coyner's left is Dr. William Carlyon of Chicago, a member of the American Medical Association staff. The third morning session speaker, Dr. Robert R. Huntley, Assistant Professor of Preventive Medicine at the University of North Carolina School of Medicine, is in the center of picture at right. With Doctor Huntley are Drs. J. C. Huffman (left) and Harold D. Almond, both of Buckhannon.

of Charleston, West Virginia Medicare Manager for Nationwide Mutual Insurance Company; Mr. Dudley Rumbaugh, Director of Hospital and Professional Relations for the Blue Cross - Blue Shield Plans of Charleston; Mrs. Oleta Riffe, Director of the Bureau of Public Health Nursing in the State Health Department; Dr. Seigle W. Parks of Charleston, Chairman of the Council of the State Medical Association; and Mr. Marco M. Rudd of Clarksburg, Assistant District Manager of the Social Security Administration.

These eight speakers participated in a panel discussion of Medicare during the 19th Annual Rural Health Conference. Front row: Mrs. Oleta Riffe, Director of Public Health Nursing, State Health Department; Dr. B. B. Richmond, Medical Director of the Health Insurance Benefits Unit, State Health Department; Mr. J. Harry Parker, Director of Administration of the Health Insurance Benefits Unit; and Mr. Marco M. Rudd of Clarksburg, Assistant District Manager, Social Security Administration. Rear: Mr. Dudley Rumbaugh, Director of Hospital and Professional Relations, Blue Cross-Blue Shield Plans of Charleston; Mr. Robert Campbell of Charleston, West Virginia Medicare Manager for Nationwide Insurance Company; Dr. N. H. Dyer, State Health Director; and Dr. Seigle W. Parks of Charleston, Chairman of the Council of the West Virginia State Medical Association.

Orthopedists Hold Meeting In Morgantown

More than 35 orthopedic surgeons from various sections of the country attended the 27th annual meeting of the Orthopaedic Guild, which was held in Morgantown, October 14-15.



Justus C. Pickett, M. D.

Dr. Justus C. Pickett, Chairman of the Division of Orthopedic Surgery at the West Virginia University School of Medicine, presided at the opening session at the WVU Medical Center.

Speakers on October 14 included: Drs. Clark K. Sleeth, Edmund B. Flink, Alexander D. Kenny, James H. McElhaney, K. Armand Fischer, Leonard T. Peterson, K. Douglas Bowers, Jack Pushkin, Lawrance S. Miller, and James H. Wiley.

After a business meeting, the members joined their wives for a picnic supper at Cooper's Rock State Park.

Saturday speakers were Drs. Bernard Zimmermann, Thomas J. Tarnay, Wayne W. Kotcamp, D. Franklin Milam and C. Leslie Mitchell.

Dr. A. C. Thompson Is Appointed To Rehabilitation Group

Dr. A. C. Thompson of Elkins, a member of the West Virginia State Medical Association, is among 15 West Virginians appointed by Gov. Hulett C. Smith to a committee which will provide leadership for a statewide comprehensive planning project in vocational rehabilitation.

The Governor noted that the Federal Vocational Rehabilitation Amendments of 1965 provide 100 per cent grants for such a planning project.

"It is hoped that by July 1, 1975, or sooner, vocational rehabilitation will be available to every handicapped individual in the entire State," Smith added.

The Federal Vocational Rehabilitation Administration has approved West Virginia's application for an $89,000 planning grant.

Dr. Ashton Succeeds Dr. Starcher On Licensing Board

Gov. Hulett C. Smith has appointed Dr. Dudley C. Ashton of Beckley to the Medical Licensing Board, succeeding Dr. Everett H. Starcher of Ripley, who resigned.

A native of Richmond, Virginia, Doctor Ashton received his M. D. degree in 1924 from Johns Hopkins University. He served a residency in internal medicine at the Medical College of Virginia Hospital, 1925-27.

Doctor Ashton is a member of the Raleigh County Medical Society and served a term on the Council of the West Virginia State Medical Association. He is a Diplomate of the American Board of Internal Medicine and a Fellow of the American College of Physicians.

Five PG Courses Announced By College of Physicians

The American College of Physicians will conduct five postgraduate courses for physicians during November and December.

They are among 20 postgraduate courses arranged by the ACP throughout the country during the current academic year. The November-December schedule is as follows:

Nov. 7-11—"Endocrine and Metabolic Disorders," Brooklyn, New York.

Nov. 14-18—"Newer Aspects of Experimental and Clinical Allergy," Boston, Massachusetts.

Nov. 28-Dec. 2—"Progress in Gastroenterology—1966," Philadelphia.

Dec. 5-9—"What the Internist Should Know About Cancer," New York City.

Dec. 14-17—"Infectious Diseases," Pittsburgh.

Fees for each course are $60 for members of the ACP and $100 for nonmembers.

Requests for information should be addressed to Dr. Edward C. Rosenow, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

Fewer Births and More Deaths In West Virginia

During the past year, West Virginia had fewer births and more deaths than in several decades past, according to State Health Director N. H. Dyer.

In a recent issue of the "State of the State's Health," Doctor Dyer reported that total births in the state were 31,958—a 10.4 per cent decrease in the birth rate over the past year. The birth rate for the state per 1,000 population was 17.5 as compared with the current national birth rate of 19.4.

In 1965, 19,121 resident deaths were recorded with a rate of 10.5 deaths per 1,000 population. Doctor Dyer said that this is an increase of 371 over the 18,750 deaths recorded in 1964. The median age at death was 69.3.

Doctor Dyer pointed out that males accounted for 51.5 per cent of West Virginia births as compared to 48.5 per cent female births. Physicians were in attendance at 99.4 per cent of all births, 98.8 per cent of which took place in a hospital.

"Although many national authorities seem alarmed at the increasing number of teenage marriages," Doctor Dyer said, "The greatest number of births to West Virginia parents occurred when the mother was 20 to 24 years of age. This age group accounted for 11,239 of the total of 31,958 births. And, the second highest number of births, 7,164, were to mothers 25 to 29 years of age."

Diseases of the heart continued to claim the greatest number of lives, both in the nation and in the state, accounting for almost 40 per cent of the total deaths in West Virginia. The 10 leading causes of death included:

(1) Diseases of the heart, 7,635 deaths, 39.9 per cent.

(2) Malignant neoplasms, 2,779 deaths, 14.5 per cent.

(3) Vascular lesions affecting central nervous system, 2,089 deaths, 10.9 per cent.

(4) Accidents, 1,165 deaths, 6.1 per cent.

(5) Pneumonia and influenza, 691 deaths, 3.6 per cent.

(6) Diseases of early infancy, 535 deaths, 2.8 per cent.

(7) General arteriosclerosis, 430 deaths, 2.2 per cent.

(8) Diabetes mellitus, 291 deaths, 1.5 per cent.

(9) Other diseases of the circulatory system, 252 deaths, 1.3 per cent.

(10) Suicide, 192 deaths, 1 per cent.

Doctor Dyer elaborated on these causes of death:

Accidental deaths accounted for 49.2 per cent of the male deaths in ages between one and 39, and, 21.4 per cent of female deaths. Accidents are the principal cause of death in each group between one and 39, and, appear among the five principal causes at all other ages through 69. Although motor vehicles accounted for 477 of these deaths, the greatest number, 637, were non-transport accidents. Of these, the largest number, 224, took place at home. Only 33 occurred at an industrial site.

Heart disease ranks as the leading cause of death for males in all age groups after 39, and, for females beginning at age 60. It appears as a principal cause of death from 15 through 99.

Malignant neoplasms are the principal cause of death for females aged 20 to 59. In age groups from 15 to 69 the proportion of deaths due to malignant neoplasms is higher for females than for males. However, in the groups from five to nine and 70 to 99, the proportion is higher for males.

Suicide appears as a principal cause of death in age groups 20 through 29, 30 through 39, and 50 through 59. The proportion of these deaths is higher for males in all groups.

Among deaths resulting from acute communicable diseases, deaths from infective and parasitic diseases totaled 170, a decrease of 64 from 1964. Tuberculosis deaths in 1965 totaled 88 with a rate of 4.8 deaths per 100,000 population. This is less than the 1964 total of 130. Syphilis deaths totaled 29, a decrease of three from the previous year. Meningococcal infections accounted for three deaths, a decrease of eight from 1964. There were no deaths resulting from poliomyelitis during the 1964 and 1965 calendar years. Deaths from measles totaled seven, compared with three in 1964. Diarrhea and enteritis numbered 71, the same as in 1964.

Cleveland Clinic Lists PG Courses

The Cleveland Clinic Educational Foundation will conduct a postgraduate course in "Medical Technology" in Cleveland on November 4.

The Foundation will offer a course in "Diagnosis and Treatment of Neuromuscular Disorders on November 16-17, and a "Postgraduate Course in Ophthalmology," December 7-8.

Additional information and detailed programs may be acquired by writing to Director of Education, The Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106.

Fall Conference and Directors Meeting In Bluefield, October 18-19

The 1966 Fall Conference and Board of Directors meeting of the Woman's Auxiliary to the West Virginia State Medical Association was held at The West Virginian Hotel in Bluefield, October 18-19.

The social program included a luncheon; a social hour at the home of Dr. and Mrs. A. J. Paine; and a dinner at Fincastle Country Club in Bluefield, Virginia.

Dr. John J. Mahood of Bluefield entertained with golfing for husbands of visiting Auxiliary Members.

PMA Publishes Catalogue

The Pharmaceutical Manufacturers Association has published a catalogue of more than 300 teaching aids prepared by 29 prescription drug producers. All materials listed are distributed or loaned free of charge.

Copies may be obtained by writing to the Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N. W., Washington, D. C. 20005.

The Journal Will Publish Association Memorabilia During Centennial Year

Almost a full century has passed since a handful of physicians gathered in a church in Fairmont to found the Medical Society of West Virginia, the progenitor of our modern West Virginia State Medical Association.

The date was April 10, 1867. West Virginia had been born a separate state of the Union less than four years before.

Next year will mark the 100th anniversary of the West Virginia State Medical Association. In the belief that a little bit of history is appropriate, your Publication Committee has been sifting through the Association archives in Charleston and elsewhere.

Among the documents available were the circular that called the April 10, 1867, meeting in Fairmont, the minutes of that meeting and the very first issue of *The West Virginia Medical Journal*, which did not appear until August, 1906.

In the coming months, *The Journal* will republish some of these old documents and writings. Most of the type styles in which they were printed have long since gone out of use, but the printers of *The Journal* will try to match the old styles as closely as possible. The re-creation of the cover of the first issue of *The Journal* (next page) is a good facsimile of the original.

Excerpts from the old Journals and other documents will be quoted in the months ahead, and where appropriate, your present day editors will add commentary.—The Publication Committee.

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To Medical Journals—

If you deem us worthy kindly put us "on your list."

To Advertisers—

"Lend a hand" and we will give you a lift.

To Physicians Who Receive Sample Copies—

Fill subscription blank another page, put in a dollar, and do it at your first examination, "lest you forget."

To Non-Members—

Join the County Society, if there is one. If none, organize and form a part of us, remembering that "in union there is strength."

CIRCULAR.

To the Medical Profession of West Virginia:

GENTLEMEN:—As a means of elevating the standard of Practical Medicine and Surgery in West Virginia, and to render quackery odious, as it deserves, the want of State medical organization is severely felt by all true cultivators of our noble science within the limits of the State.

In West Virginia the profession is, at many points, adorned by one or more active, intelligent members, who, by their industry and devotion to science, have made for themselves a name outside of their fields of labor; and there are others, too, of modest talent, scattered here and there, who but require the contact and association which a proper organization would so surely effect, to develop latent powers and capabilities of great credit to themselves, individually, and beneficial, in the highest degree, to their patients and the commonwealth of medicine.

There is much labor to be performed by the profession in West Virginia before it can reach the standard of respectability, which is its legitimate inheritance in some of the sister States. Disease and death do not relax their hold in favor of our mountains and valleys. On the contrary, some of these are the very strongholds of the enemy; and before his ravages can be stayed, the inhabitants must be taught the laws of Hygiene, and be able to mark the difference existing between the true and false—the intelligent physician and the murderous pretender, who is everywhere present with the offer of his ignoble service. These important lessons none but competent medical men can teach; and it is high time they should begin the noble work of giving life and health to the people, and respectability to themselves.

Organization would necessitate interchange of opinion on subjects connected with the different branches of the profession, and, besides the profit and pleasure of regular communications, habits of closer study and more patient investigation would be encouraged; the demand for classic and periodical literature largely increased—and these would be the signs of our improved *status*.

To accomplish all these excellent ends, it is proposed to organize a State Medical Society; and in order to formally initiate the movement, the undersigned have, upon consultation, agreed to issue this call for a convention to assemble in Fairmont on the 10th day of April next. The call is urged upon all members of the regular profession, and their presence in the proposed convention is earnestly solicited. A full attendance is desired, not only on account of the interest connected with the organization of the State Society, but also because the American Medical Association will meet in Cincinnati early in May, and the profession of this State should be represented in it, in accordance with the expressed desire of the Association.

THOMAS KENNEDY, Grafton,
H. W. BROCK, Morgantown,
J. C. HUPP, Wheeling,
E. A. HILDRETH, Wheeling,
R. H. CUMMINS, Wheeling,
W. J. BATES, Wheeling,
A. S. TODD, Wheeling,
JAMES CUMMINS, Wheeling,
JOHN FRISSELL, Wheeling,
J. W. RAMSEY, Clarksburg,
J. M. BLACKFORD, Clarksburg,
J. M. BOWCOCK, Clarksburg,
JAS. E. REEVES, Fairmont,
D. S. PINNELL, Buckhannon,
G. A. CRACRAFT, Triadelphia,
JNO. H. STORER, Triadelphia.

February 28, 1867.

Minutes of First Meeting in April, 1867

(Excerpts)

The State Medical Convention assembled at Fairmont in the Methodist Protestant Church on the 10th day of April 1867, pursuant to a call bearing the date, February 28, 1867.

Dr. H. W. Brock of Morgantown called the meeting to order and on his motion, Dr. J. W. Bates of Wheeling, was selected as temporary president and Dr. J. E. Ramsey of Clarksburg, as Secretary. Twenty-two physicians answered the call and they represented ten counties.

Dr. James E. Reeves of Fairmont, chairman of the committee on arrangements, welcomed the convention with an eloquent and long oration. Doctor Reeves also announced that the B & O Railroad Company would transport the members to their homes free of charge.

A committee on permanent organization reported and Dr. J. W. Bates was reported as permanent President of the convention.

On motion of Doctor Hupp, it was resolved that it be expedient to establish and organize a permanent Medical Society for the State of West Virginia.

A committee was appointed to report a Constitution and By-Laws for the government of the Society. The committee retired and after several hours labor reported a Constitution and By-Laws which were unanimously adopted (It soon became a matter of serious discussion). At the evening session of the same day, the committee on nominations reported for president, Dr. John Frissell, of Wheeling. This action was ratified by the Society. The next place of meeting was to be Wheeling and the date—the first Wednesday in October. Bills of $3.50 and $4.50 were ordered to be paid.

It was moved that "Is the Disease Called Progressive Locomotor Ataxy a Distinct Disease from General Paralysis?" be made the subject for discussion at the next meeting of the society.

IN RETROSPECT 100 YEARS LATER

The Medical Society of West Virginia began its first semi-annual meeting on October 2nd, 1867, in the hall of the House of Delegates, in Wheeling, with Dr. John Frissell in the chair. There were 32 members present. Dr. John C. Hupp of Wheeling made the address of welcome. The President's address delivered by Doctor Frissell was very long, but makes excellent reading even after 100 years. He paid tribute to the great new State of West Virginia and foresaw a brilliant future for it. He speculated, "What will be the condition of West Virginia, a century hence?" He marveled at the telegraph, the steam engine and the railroads. He hoped that the pioneers in medicine would see that the plans for the high standing and usefulness of medicine in West Virginia were well laid. He said the Society should elect only those members of the profession who were properly qualified to practice medicine and whose professional character and rectitude were of the highest standing.

A resolution was passed urging the Legislature to enact a law for the compulsory registration of births, deaths and marriages and to include compulsory vaccination for small pox (The Legislature did not make reporting of communicable diseases mandatory until 1907. The Division of Vital Statistics was created by the Legislature in 1921).

The Society was welcomed to Wheeling by Mayor Sweeney. His Excellency, Governor Boreman, had been quite unwell for several days, but his respect for the Society and the interest he felt in its objects constrained him to be present even under most adverse circumstances. Scientific papers were read on sanitary science, treatment of membranous diphtheria with inhalation of lime, fatal cutaneous diphtheria and military medicine. Several unusual cases were presented—(apparently Locomotor Ataxy was forgotten).

There was considerable discussion about the Constitution. Semi-annual meetings were too frequent. The section which provided that five members at a meeting would constitute a quorum might permit the control and direction of the Society to fall into the hands of five or six men. The Constitution at this time was about three times as long as that of the medical societies of Philadelphia and Baltimore. There were too many irregular admissions. Prominent physicians got into the society by simply paying the dues and not through the constitutional procedure of the ballot.

The Wheeling meeting closed with a delightful address from Doctor Reeves of Fairmont. The Society then adjourned to visit the Fair Grounds on Wheeling Island.

The Medical Society of West Virginia now had 62 members (October 1867).

West Virginia Medical Journal Makes Its Debut

Number 1, Volume 1, of the West Virginia Medical Journal, is a sturdy little number of 50 pages, which came into being in August, 1906, two months after the State convention of the West Virginia State Medical Association in Webster Springs in June of 1906, and 39 years after the birth of the West Virginia Medical Society, at Fairmont, on the 10th day of April in 1867.

The Committee on State Journal reported to the House of Delegates on the 20th of June, 1906, "That at this time we have not sufficient membership to justify the publication of a Journal." A day later the House of Delegates directed the Committee on Publication to proceed with the publication of a Journal forthwith. The Journal should include, the Procedures of the Association and Publication of the "Procedures" should cease.

The Convention Issue, Number 1, contained a full report of the business of the House of Delegates, the Council and many of the papers presented at the convention. There were advertisements from several hospitals, sanatoria, pharmacies, laboratories, medical schools and Sweet Melody Rye Whiskey.

Number 1, Volume 1, is brittle, shabby and coming apart at the seams. Before further ravages, it is hoped it can be copied for medical posterity.

The following words of wisdom were published in the first issue and the author was Dr. S. J. Jepson of Wheeling, Chairman of the Committee on Publication:

HERE WE ARE.

The West Virginia Medical Journal, with its very best bow, steps modestly into the charmed circle of State Medical Society Journalism, and hopes for a warm welcome. Receive us with a cheerful smile, encourage with a word of commendation when deserved, stimulate by kind suggestion and criticism when needed, help by contributions from your observations and experience, and we will remain with you. Unkind complaint does no good and is discouraging to honest effort. Let every one give his aid, and the best results will follow, and The Journal will live and grow and do good. S. L. J.

WHY WE ARE HERE.

As will be seen by reading the minutes of the House of Delegates of our State Medical Association, that body, at its meeting in June, directed the Committee on Publication to issue a periodical Medical Journal instead of the annual volume of Transactions. The writer, who has served on the publishing committee twenty years of the Society's existence, appeared before the Delegates and made an argument against the establishment of a Journal until our membership be increased, and especially until data could be presented showing approximately the cost of such a periodical, and the probable income from subscriptions and advertisements. The House, by an almost unanimous vote, expressed its "want of confidence" in the views of the speaker, and as loyal and obedient members of our State Association the Committee on Publication went to work to execute the order of the House of Delegates, and as the result presents this first number of your Journal. The writer is glad to say, that correspondence with the editors of our sister State Association Journals has convinced him that the judgment of the House of Delegates was wiser than his own.

In starting this new enterprise, your committee has no policy to lay down in advance, preferring to "clothe its purpose in the sober fabric of performance rather than in the showy gauze of promise." For the present we simply give you the best efforts of our editorial inexperience. As long as the Journal is under the present management, however, it will be directed in the interest of the medical profession generally, but particularly in the interest of the organized profession, as collected in the County and State Societies.

Knowing that no one is infallible, we shall exercise the largest charity towards all with whom we may have dealings, whenever they appear to be striving to act fairly and honestly. The golden rule is a safe guide for all, and no one can go far wrong who adopts it for daily use. Feeling quite sure that every physician who honestly and earnestly desires to further, not only the best interests of the profession

but his own professional progress, will best accomplish those purposes by close affiliation with his fellow-workers, it shall be our constant endeavor to stimulate the organization and growth of County Societies. To this end we now urge the many excellent young men who have recently entered upon their professional career in this State, to at once connect themselves with their County Society, if there be one. In counties having no organization, the reputable physicians should meet for conference, adjust past differences, if need be, forgive past errors and indiscretions, make new resolves, and organize.

Frequent close contact of men engaged in the same profession enables them to estimate each other at their true value, and differences can be thus more readily adjusted, for the sins of our fellows of which we sometimes hear grow beautifully less when we know them better. How much more delightful our whole professional life would be, could we habitually exercise charity towards our brethren, inquiring of ourselves, before passing judgment, "how would we have acted under similar circumstances?" Down at the bottom, the human heart is kind, as is seen in times of distress and suffering. Very many risk their lives to save the drowning, spend their time freely to relieve pain and distress, give of their slender means when the great trial comes. Why can we not, in the ordinary walks of life, constantly show the best that is in us, thus lightening the burdens of others and making our own pathway in life more bright!

"God, what a world, if men in street and mart
Felt the same kinship of the human heart
Which makes them, in the face of flame and flood,
Rise to the meaning of true brotherhood!

Come together, then, as brethren engaged in the same noble, self-sacrificing calling, talk over the interests of the profession, smooth down the rough places in your own disposition, and organize your county. If you be but half a dozen, if you be able to meet but twice a year, you will be in touch with your State Society and with the great American Medical Association. You will be entitled to representation in the annual meetings of the State Society and will receive its Journal, and thus you will be made to feel, as you never felt before, that you are part of a noble brotherhood of men, working unselfishly in a common cause. Organize! S. L. J.

Other Interesting Items in First Issue

The address of the President, Dr. S. S. Wade of Morgantown, concerned "The Standard of Medical Education as Advanced by Organization." The Secretary, Dr. W. W. Golden of Elkins, read an excellent paper on "The County Society" and stated; "Take care of the county society and our State and National Bodies will take care of themselves." An interesting case history was told by Dr. J. E. Irons of Elkins, about Marron John Rashid, West Virginia's famous leper.

The Publication Committee especially liked these items:

> Cannot the officers of the societies in the larger cities send us some valuable ads? Blank rates and contracts sent on application. In no other way than through the Journal can 1,200 or more West Virginia physicians be reached by advertisers so easily, so certainly and so cheaply.
>
> ---
>
> Our advertisers are all reliable. We desire no other kind. Patronize them, and tell them that you saw their ad in our Journal. Thus we may hold them and win others.—S. L. J.

The State Board of Health in announcing the results of the last licensing examination, said 44 physicians took the examination and 12 passed; of the failures 11 did not have an M. D. degree. The Board stated "It is no less than disgraceful to the state, that the law makes it possible for a non-graduate to enter upon the practice of medicine."

Evidently there existed, even then, a degree of suspicion between Specialists and Generalists. A paper was read with this obtuse subject; "The Ethics of the Specialist and His Assumption of Ignorance of the General Practitioner."

"The Journal has been sent to several hundred physicians who are neither subscribers nor members of the State Medical Association. We urge all such to send their subscription of one dollar at once. We need their aid and co-operation, and are quite sure they will receive more than a dollar's worth of profit and pleasure from reading the excellent papers presented by our contributors, and the news items we hope to present from all parts of the State. Let State pride stimulate you to support your home Journal. Send your dollar now!"

A prime function of a state medical journal is to report the news of the association and in so doing record the history of the society. Number 1, Volume 1, fulfills this purpose admirably.

(TO BE CONTINUED)

1867 CENTENNIAL YEAR 1967

Southern Medical Association Meeting in Washington

An excellent scientific program and a slate of social activities have been arranged for the 60th Annual Meeting of the Southern Medical Association, which will be held in Washington, November 14-17.

Albert C. Esposito, M. D.

Milford O. Rouse, M. D.

SMA has 22 scientific sections, each of which will have programs. They are as follows: allergy; anesthesiology; dermatology; gastroenterology; general practice; gynecology; industrial medicine and surgery; medicine; neurology and psychiatry; obstetrics; ophthalmology; orthopedic and traumatic surgery; otolaryngology; pathology; pediatrics; plastic and reconstructive surgery; physical medicine and rehabilitation; preventive medicine; proctology; radiology; surgery; and urology.

Dr. Albert C. Esposito of Huntington, Past President of the West Virginia State Medical Association and the Vice Chairman of the Executive Committee of SMA, will lead a delegation of West Virginia physicians to the meeting.

In addition to the sectional meetings, there will be general sessions; scientific and technical exhibits; scientific color television; and conjoint society meetings.

Dr. Milford O. Rouse of Dallas, Texas, President Elect of the American Medical Association and a Past President of SMA, will be guest speaker at the President's Luncheon at the Washington Hilton on Tuesday, November 15.

Several physicians from West Virginia have parts in the scientific program.

Dr. Daniel Hamaty of Charleston will present a paper entitled "Abrupt Corticosteroid Withdrawal from the Rheumatoid Arthritis Patient" before the Section on Medicine on November 16.

Also on November 16, Doctor Esposito will serve as Discussant for a paper entitled "Lacerations of the Cornea and Sclera and Their Management: A Five Year Study." The paper will be read By Dr. Leonard R. Rue of New Orleans before the Section on Ophthalmology.

Dr. D. Franklin Milam of Morgantown will narrate a scientific motion picture entitled "Internal Urethrotomy of Female Urethra with New Urethrotomes" at a joint meeting of the Sections on Pediatrics and Urology.

Dr. Charles E. Andrews of Morgantown will be a panelist for a discussion of "Pleural Effusion: Diagnosis and Treatment" on November 14.

Other functions will include:

A reception on Sunday, November 13, honoring the President, Dr. J. Garber Galbraith of Birmingham, Alabama; the annual dinner dance on Wednesday, November 16; a golf tournament on November 15; various medical school alumni reunions; and activities for members of the Woman's Auxiliary.

Smith Kline & French Laboratories will present a seminar on effective public speaking. This program will be held for three hours on Wednesday afternoon, November 16, and on Thursday morning, November 17.

Additional information about the meeting may be obtained by writing to Southern Medical Association, 2301 Highland Avenue, Birmingham, Alabama 35205.

Dr. Thomas L. Harris Is Honored By Parkersburg Hospital

A portrait of Dr. Thomas L. Harris, a Past President of the West Virginia State Medical Association, has been hung in the lobby of St. Joseph's Hospital in Parkersburg.

Thomas L. Harris, M. D

The hospital's medical staff voted to honor Doctor Harris in this manner in recognition of his efforts in obtaining the hospital, the School of Nursing building and the hospital annex.

Doctor Harris, a resident of Parkersburg since 1915, was a member of the hospital staff for 50 years and served as chief of staff for several years.

The drive that resulted in the existing hospital began at a dinner that Doctor Harris had for 24 men in 1929. The group agreed that a new hospital was needed, and Mother Dominick, then administrator of the old St. Joseph's Hospital, received approval from the late Bishop John J. Swint of Wheeling to conduct a drive to raise $300,000.

Although the campaign began the day of the stock market crash in 1929, the drive was oversubscribed by $65,000. The hospital, opened in 1931, cost $500,000, part of which was financed.

Seminar in Cancer Research

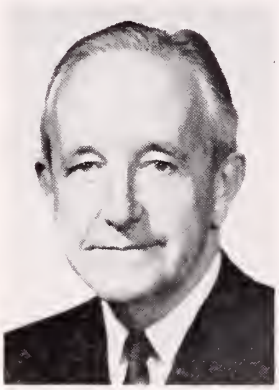
The Georgetown University Medical Center will present a seminar on "Clinical Applications of Advances in Cancer Research" in Washington on March 11, 1967.

Additional information may be obtained by writing to the Division of Oncologic Surgery, Georgetown University Medical School, Washington, D. C. 20007.

20th Annual AMA Clinical Convention Planned in Las Vegas

The 20th Annual Clinical Convention of the American Medical Association will be held in Las Vegas, Nevada, November 27-30.

Dr. Charles L. Hudson of Cleveland, who was installed as President of the AMA in Chicago in June, will preside at the sessions, which will feature meetings of the House of Delegates and scientific sessions.



Charles L. Hudson, M. D.

The West Virginia State Medical Association will be represented in the AMA House of Delegates by Drs. Frank J. Holroyd of Princeton and C. A. Hoffman of Huntington. AMA Alternates for West Virginia are Drs. Thomas G. Reed of Charleston and D. E. Greeneltch of Wheeling.

Scientific Program

The four-day meeting will include scientific sessions on 18 major topics, three postgraduate courses, breakfast roundtable discussions, closed-circuit television and medical motion picture programs in addition to a variety of scientific exhibits.

There will be three topics for the postgraduate courses—obstetrics and gynecology, fluid and electrolyte balance and cardiovascular disease. There will be a $10 registration fee for each course, which will consist of three half-day sessions.

Topics for the Breakfast Roundtable Conferences will be "An Agonizing Reappraisal of Cancer Chemotherapy," "The Problem and Potential of LSD," "The Management of Metabolic Bone Disease," and "Indication for Cardioversion."

The scientific sessions will include discussion of such topics as scintillation scanning; radiation and cancer; clinical pulmonary physiology, gastroenterology; futuristic diagnostic and therapeutic tools; neck pain; antibiotics; urology; aerospace medicine, unconsciousness; dermatology; juvenile diabetes; endocrine and metabolic diseases, pediatrics, surgery, hematology, psychiatry and otolaryngology.

Scientific and industrial exhibits and all scientific meetings will be in the newly expanded Las Vegas Convention Center. The House of Delegates will meet in the Dunes Hotel and Caesar's Palace.

Medical Aspects of Sports

The Eighth National Conference on the Medical Aspects of Sports will be held in conjunction with the meeting. The meeting on Sunday, November 27, at Caesar's Palace, will be a day-long program of discussion of problems faced by team physicians at all levels of athletic competition.

Advance Registration

Physicians may register in advance for the Clinical Convention by writing to the Circulation and Records Department, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Information on hotel reservations may be obtained by writing to the AMA Housing Bureau, Las Vegas Convention Bureau, Convention Center, Paradise Road, Las Vegas, Nevada.

Dr Carroll L. Witten Installed As President of AAGP

Dr. Carroll L. Witten of Louisville, Kentucky, was installed as President of the American Academy of General Practice during the group's Annual Scientific Assembly in Boston on October 12.

Doctor Witten is one of eight new officers who took office at the closing session of the 1966 Congress of Delegates, He succeeds Dr. Amos N. Johnson of Garland, North Carolina.

The new President Elect of the Academy is Dr. George E. Burket, Jr., of Kingman, Kansas.

Other new officers include: Dr. Maynard I. Shapiro of Chicago, Vice President; Dr. John C. Ely of Spokane, Washington, reelected Speaker of the Congress of Delegates; and Drs. Lloyd G. Davies of Fryeburg, Maine, Roger Neil Chisholm of Denver, Colorado, and William Lotterhos of Jackson, Mississippi, elected directors for three-year terms.

Some 3,500 physicians attended the business and scientific sessions.

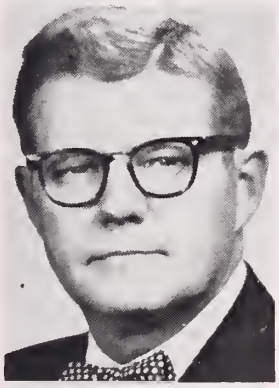
Dr. Seigle W. Parks of Charleston, Chairman of the Council of the West Virginia State Medical Association, was head of the Committee that planned the scientific program. Doctor Parks and Dr. Carl B. Hall of Charleston represented the West Virginia AAGP Chapter in the Congress of Delegates.

The Program Committee met in Charleston on October 2 to begin planning the scientific program for the 100th Annual Meeting. In front are Dr. Richard E. Flood of Weirton, President of the West Virginia State Medical Association, and Dr. Ray S. Greco of Weirton, Committee Chairman. Rear: Dr. Richard W. Corbitt of Parkersburg, Vice President of the Association and a member of the Committee, and Dr. Robert Greco of Morgantown, a member of the Committee.

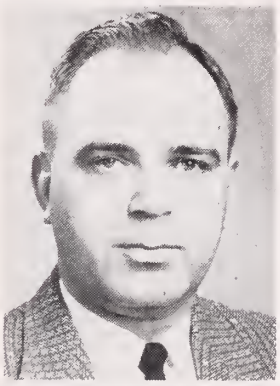
Dr. Herbert E. Warden Heads Heart Association

Dr. Herbert E. Warden of Morgantown, Professor of Surgery at the West Virginia University School of Medicine, was installed as President of the West Virginia Heart Association during the group's annual meeting in Morgantown, September 23-24.

He succeeds Dr. Albert C. Kistin of Beckley.



Herbert E. Warden, M. D.



A. C. Edmundowicz, M. D.

Other new officers include Dr. Alphonse C. Edmundowicz of Morgantown, President Elect; Dr. D. Sheffer Clark of Huntington, Vice President; and P. J. Corbitt, D. D. S., of Parkersburg, Chairman of the Board. Mr. Jack L. Lewis of Bluefield and Miss Mary Helen Thompson of Charleston were re-elected Secretary and Treasurer, respectively.

New Board Members

Among the newly-elected members of the Board of the Heart Association are the following physicians:

Drs. Martha Jane Coyner of Harrisville; Sam Milchin of Bluefield, Virginia; Edwin C. Neville of Charleston; Thomas J. Tarnay of Morgantown; Zeb C. Burton, Jr., of Huntington; and Richard G. Starr of Beckley.

In addition, three physicians were elected as Honorary Members of the Board for their long and faithful service to the Heart Association.

They are: Dr. William A. Thornhill of Charleston; and Drs. Edward J. Van Liere and F. R. Whittlesey, both of Morgantown.

Keynote Address

Dr. Russell V. Lucas of the University of Minnesota, formerly of the West Virginia University School of Medicine, presented the keynote address at the first Annual Assembly.

In a paper entitled "Triumph and Tragedy," Doctor Lucas said that a tragedy of our time is the fact that many people of all ages are stricken each year by more than 20 cardiovascular diseases.

The triumph, he said, is that tremendous gains have been realized in recent years in cardiovascular medicine.

A Diplomate of the American Board of Surgery, Doctor Warden received the Albert E. Lasker Award for Medical Research from the American Public Health Association in 1955.

College of Surgeons Inducts Four Association Members

Four members of the West Virginia State Medical Association were among 1,350 surgeons who were inducted on October 13 as Fellows of the American College of Surgeons during the annual five-day Clinical Congress in San Francisco.

The new West Virginia Fellows are Drs. Charles A. Hoffman, Jr., and George B. Irons, Jr., both of Huntington; Edwin C. Neville of Charleston; and Paul E. Prillaman, Jr., of Ronceverte.

The ACS is a scientific, educational and voluntary association of surgeons, numbering 27,000 Fellows in 83 countries. The College was founded in 1913.

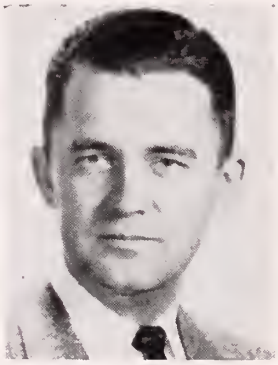
Dr. Richard E. Flood of Weirton, President of the West Virginia State Medical Association, (left in left picture) confers with Dr. Charles T. Lively of Weston, retiring President of the Central West Virginia Medical Society, at the Society's Fall Meeting in Buckhannon on October 5. New officers of the Society are shown in right photograph. Left to right: Dr. Louis W. Groves, Jr., of Richwood, Vice President; Dr. George T. Hoylman of Gassaway, President; and Dr. R. L. Chamberlain of Buckhannon, Secretary-Treasurer.

Dr. David B. Gray Heads Cancer Society

Dr. David B. Gray of Charleston was elected President of the West Virginia Division of the American Cancer Society during the Division's annual meeting at Cacapon State Park, September 30-October 2.

A native of Rainelle, Doctor Gray attended West Virginia Wesleyan College and received his M. D. degree from the University of Maryland. He is a Diplomate of the American Board of Surgery and is a Fellow of the American College of Surgeons.

David B. Gray, M. D.



Alvin L. Watne, M. D.

Doctor Gray's other professional memberships include the West Virginia State Medical Association, the Society of Head and Neck Surgeons, the James Ewing Society and the University of Maryland Surgical Society.

While serving as a member of the American Cancer Society's Board of Directors, Doctor Gray established its Simplified Service Program for cancer patients which has greatly expanded the program.

Doctor Watne Elected Vice President

Dr. Alvin L. Watne, Associate Professor of Surgery at the West Virginia University School of Medicine, was named Vice President of the Division. Other new officers include:

Mrs. David N. Thomas of Weirton, Chairman of the Executive Committee; Miss Marjorie Scott of Wheeling, Secretary; and Max W. Saunders of Charleston, Treasurer.

Board of Directors

The following District Directors were elected:

Drs. Jack Burnett of Wheeling; Hugh H. Cook, Jr., of Elkins; L. Walter Fix of Martinsburg; David B. Thornburg of Parkersburg; Paul E. Prillaman, Jr., of Ronceverte; James P. Carey of Huntington; Gray; W. E. Copenhaver of Bluefield; E. R. Chillag of Logan; and John L. Campbell, D. D. S., of Morgantown.

The following lay directors were elected:

Mrs. W. W. Barron of Charleston; Mr. Charles M. Brenneman of Weirton; State Senator W. T. Brotherton, Jr., of Charleston; Mr. Norris Kantor of Bluefield; former Gov. Cecil H. Underwood of Huntington; Mr. Maxwell R. Roth of Huntington; former U. S. Sen. Chapman Revercomb of Charleston; Mr. Max W. Saunders of Charleston; Mrs. David N. Thomas of Weirton; and Mr. Albert Tieche of Beckley.

Health Department to Sponsor Retardation Seminar

The State Health Department will sponsor a seminar on "Mental Retardation—Prevention and Potential" at the State Capitol in Charleston on November 14-15.

Several members of the West Virginia State Medical Association will participate in the program.

Dr. Clark K. Sleeth, Dean of the West Virginia University School of Medicine, will preside at the morning session on November 14. Morning speakers will include: Mrs. Hulett C. Smith; Dr. N. H. Dyer,

N. H. Dyer, M. D.

Emma Jane Freeman, M. D.

State Health Director; and Dr. Winslow Tompkins of the Department of Health, Education and Welfare in Washington.

Afternoon speakers will include Dr. J. William Oberman of HEW; Dr. Nicholas W. Fugo, Chairman of the Department of Obstetrics and Gynecology at the WVU School of Medicine; and Dr. W. Gene Klingberg, Chairman of the Department of Pediatrics at WVU. Dr. Emma Jane Freeman, head of the State Health Department's Division of Maternal and Child Health, will preside.

Doctor Klingberg will present another paper Tuesday morning. Other Tuesday morning speakers will include Dr. Harold M. Nitowsky of Sinai Hospital, Baltimore; and Donald Harrington, Ph. D., of HEW in Washington.

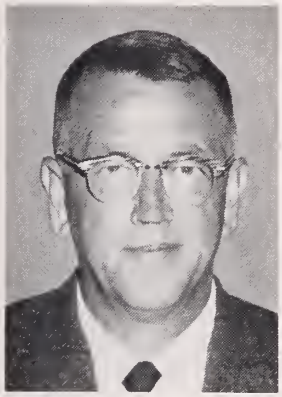
On Tuesday afternoon, papers will be presented by Allen Blumberg, D. Ed., Coordinator of the West Virginia Commission on Mental Retardation; Stanley H. Martin, Ph. D., President of West Virginia Wesleyan College; and Dr. Richard E. Flood of Weirton, President of the West Virginia State Medical Association.

WANTED

The Editorial Board is interested in obtaining the proceedings of annual meetings of the West Virginia State Medical Association from 1875 to 1900, as well as for the year 1905. Original material will be returned to the owner after it has been copied.

Medical Education Program In Wheeling on Nov. 13

The complete schedule of speakers has been announced for the Ohio Valley General Hospital's Postgraduate Medical Education Program, which will be held at Oglebay Park in Wheeling on Sunday, November 13.



Walter H. Gerwig, M. D.

There will be a registration fee of $5, which includes a buffet luncheon. Fees will be waived for residents, interns and medical students.

Two papers will be presented at the morning session, which begins at 10 A. M. The morning program is as follows:

"Surgery in the Treatment of Chronic Duodenal Ulcer"—Stanley O. Hoerr, M. D., Chairman, Division of Surgery, The Cleveland Clinic.

"The Contributions of Intracardiac Phonocardiography to Clinical Auscultation of the Heart"—Joseph M. Ryan, M. D., Professor of Medicine, Ohio State University School of Medicine.

Following lunch, the scientific program will be divided into three sections—surgery, medicine and pediatrics and obstetrics-gynecology. The afternoon program is as follows:

Surgical Section

"Treatment of Pulmonary Embolism"—Edward C. Voss, M. D., Department of Surgery, Ohio Valley General Hospital.

"Extra-aortic Aneurysms of the Abdomen"—Charles D. Hershey, M. D., Department of Surgery, Ohio Valley General Hospital.

"Assisted Circulation in Community Hospitals"—Robert J. Reed, M. D., Department of Surgery, Ohio Valley General Hospital.

"Respiratory Problems in the Surgical Patient"—Robert S. Robbins, M. D., Department of Anesthesiology, Ohio Valley General Hospital.

"Treatment of Acute Cholecystitis"—Stanley O. Hoerr, M. D., Chairman, Division of Surgery, the Cleveland Clinic.

"Diagnostic Measures to Aid in Detecting the Site of Upper Gastrointestinal Hemorrhage"—Walter H. Gerwig, M. D., Chief of Surgery, Veterans Hospital, Clarksburg, and Professor of Surgery, West Virginia University School of Medicine.

Medical Section

"The Principles of Cardiac Resuscitation"—Albert M. Valentine, M. D., Department of Medicine, Ohio Valley General Hospital.

"The Angiographic Evaluation of the Hypertensive Patient"—Joseph L. Curry, M. D., Department of Radiology, Ohio Valley General Hospital.

"Atypical Pain in Coronary Heart Disease"—Howard R. Sauder, M. D., Department of Medicine, Ohio Valley General Hospital.

"Interpretation of Serum Enzyme Values in Patients with Suspected Coronary Artery Disease and Chest Pain"—Ross O. Bell, Jr., M. D., Department of Clinical Pathology, Ohio Valley General Hospital.

"Bacterial Endocarditis, a Ten Year Review in a Community Hospital"—Michael J. Caruso, M. D., Department of Medicine, Ohio Valley General Hospital.

"Cine Coronary Arteriography in the Diagnosis of Coronary Artery Disease"—William C. Sheldon, M. D., Department of Pediatric Cardiology, The Cleveland Clinic.

Pediatrics and Ob.-Gyn. Section

"Intrauterine Exchange Transfusions"—Donald L. Hutchinson, M. D., Chairman, Department of Obstetrics and Gynecology, University of Pittsburgh School of Medicine.

"Radiographic Assessment of Fetal Size"—Robert T. Brandfass, M. D., Department of Obstetrics and Gynecology, Ohio Valley General Hosiptal.

"Diagnosis of Obscure Pelvic Tumors by Gynecography"— Fernando G. Giustini, M. D., Department of Obstetrics and Gynecology, Ohio Valley General Hospital.

"Pediatric Radiology"—John P. Caffey, M. D., Visiting Professor of Diagnostic Radiology and Pediatrics, University of Pittsburgh School of Medicine.

"Management of Erythroblastosis Fetalis"—Robert A. Lewine, Department of Pediatrics, Ohio Valley General Hospital.

"Pediatric Dermatology"—Harold L. Saferstein, M. D., Department of Medicine-Dermatology, Ohio Valley General Hospital.

The program has been approved for four hours of credit by the American Academy of General Practice.

Additional information may be obtained from Dr. R. S. Robbins, 8 Hazlett Court, Wheeling, West Virginia.

Dr. Richard A. Currie Participates In Viet Nam Project

Dr. Richard A. Currie of Morgantown, Associate Professor of Surgery at the West Virginia University School of Medicine, left October 29 for a 60-day tour of duty in civilian hospitals of South Viet Nam.

Richard A. Currie, M. D.

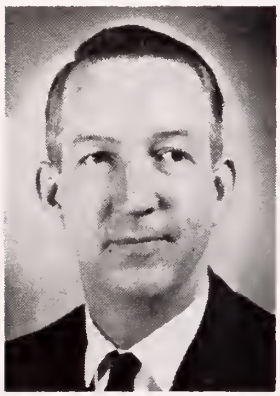
Doctor Currie volunteered to serve in Viet Nam under the American Medical Association's "Volunteer Physicians for Viet Nam" program. Up to 32 general practitioners, internists and surgeons are required every month for the program.

Requirements for volunteers are that the participants be in good health and not more than 55 years of age. No dependents may accompany them.

Dr. Robert W. Neilson of Bluefield returned home during the summer after a similar two-month assignment.

Medical Education Conference In Charleston on Nov. 13

The Committee on Medical Education and Hospitals of the West Virginia State Medical Association will sponsor a Medical Education Planning Conference at The Daniel Boone Hotel in Charleston on Sunday, November 13.



David Z. Morgan, M. D.

Daniel Hamaty, M. D.

Dr. Pat A. Tuckwiller of Charleston, the Chairman, said the purpose of the Conference would be to determine ways of coordinating and encouraging more effective postgraduate medical education in West Virginia. Approximately 80 representatives of private and public health agencies; professional sections, societies and associations affiliated with the State Medical Association; the West Virginia University School of Medicine; and teaching hospitals have been invited to the Conference.

The meeting will begin at 11 A.M. with an address of welcome by Dr. Richard E. Flood of Weirton, President of the State Medical Association.

Dr. Clark K. Sleeth of Morgantown, Dean of the WVU School of Medicine and a member of the Committee, will preside at the morning session, which will consist of the presentation of two papers as follows:

"The Role of the West Virginia University Medical Center in Graduate and Postgraduate Medical Education"—David Z. Morgan, M. D., Assistant Dean, WVU School of Medicine.

"The Role of the Community Hospital in Graduate and Postgraduate Medical Education"—Daniel Hamaty, M. D., Director of Medical Education, Memorial Hospital, Charleston.

Afternoon Session

Doctor Tuckwiller will preside at the afternoon session, which will consist of a roundtable discussion. Organizational representatives will be called upon to give their views of the medical education program as proposed by the Committee and to describe ways they may be of assistance.

Association Members Invited

The meeting is open to all members of the State Medical Association who are interested in graduate and postgraduate medical education. Notice of intent to attend the meeting should be sent to Dr. Pat A. Tuckwiller, West Virginia State Medical Association, P. O. Box 1031, Charleston, West Virginia 25324.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1966

Nov. 6-9—Med. Soc. of Virginia, Williamsburg.
Nov. 14-17—Southern Med. Assn., Washington.
Nov. Am. Medical Womens Assn., Washington.
Nov. 26-27—Am. Col. of Chest Physicians, Las Vegas.
Nov. 27-30—AMA Clinical Convention, Las Vegas.
Nov. 27—Nat. Conf. on the Med. Aspects of Sports, Las Vegas.
Nov. 29-Dec. 1—Am. Acad, for Cerebral Palsy, Biloxi-Gulfport, Miss.
Dec. 1—Am. Epilepsy Soc., New York City.
Dec. 2-3—Am. Rheumatism Assn., Cincinnati.
Dec. 3-6—Am. Acad. for Cerebral Palsy, New Orleans.
Dec. 3-8—Am. Acad. of Dermatology, Bal Harbour, Fla.
Dec. 4-7—Am. Soc. of Hematology, New Orleans.
Dec. 6-8—Southern Surgical Assn., Boca Raton, Fla.

1967

Jan. 14-19—Am. Acad. of Orthopaedic Surgeons, San Francisco.
Jan. 20-21—ACP Regional Meeting, Morgantown.
Jan. 23-25—Soc. of Thoracic Surgeons, Kansas City.
Jan. 31-Feb. 4—Am. Col. of Radiology, Chicago.
Feb. 8-10—Am. Acad. of Occupational Med., San Francisco.
Feb. 9-15—AMA Cong. on Med. Ed., Chicago.
Feb. 14-19—Am. Col. of Cardiology, Washington.
Feb. 18-22—Am. Acad, of Allergy, Palm Springs, Calif.
Feb. 23-25—Cen. Surg. Assn., Pittsburgh.
Feb. 28—Nat. Multiple Sclerosis Soc., New York.
March 9-11—AMA-ABA National Medicolegal Symposium, Miami Beach.
March 10-11—AMA Conf. on Rural Health, Charlotte, N. C.
March 16-18—Sou. Soc. of Anesthesiologists, Charleston, S. C.
March 19-24—Southeastern Surgical Cong., Bal Harbour, Fla.
March 19-24—Am. Col. of Allergists, New Orleans.
April 3-5—Am. Acad. of Ped., San Francisco.
April 7-9—Am. Soc. of Int. Med., San Francisco.
April 10-13—Indus. Med. Assn., New York City.
April 10-14—Am. Col. of Physicians, San Francisco.
April 16-20—Am. Col. of Ob. & Gyn., Philadelphia.
April 17-19—Am. Assn. for Thoracic Surgery, New York.
April 19-21—Maryland Medical, Baltimore.
April 23-26—W. Va. Acad. of Oph, and Otol., White Sulphur Springs.
April 27-28—Am. Ped Soc., Atlantic City.
April 30-May 2—W. Chapter, AAGP, Huntington.
April 30-May 5—Int. Col. of Surgeons, Bal Harbour Fla.
May 3—Am. Cancer Soc., Dallas.
May 6—Am. Col. of Psychiatrists, Philadelphia.
May 11-14—Am. Surg. Assn., Colorado Springs.
May 29-June 1—Am. Urol. Assn., New York.
May 21-24—Am. Thoracic Soc., Pittsburgh.
June 18-22—AMA Annual Con., Atlantic City.

Aug. 24-26—100th Annual Meeting, W. Va. State Medical Assn., The Greenbrier, White Sulphur Springs.

The West Virginia Medical Journal

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Clinical Application of Radioactive Isotopes In Brain Scanning

George G. Green, M. D., G. Robert Nugent, M. D., and Francis A. Goad, M. D.

The diagnostic value of brain scanning with radioactive isotopes now has become firmly established.

Many clinicians still associate this procedure only with the study of the brain tumor suspect, where, according to various authors, it has proved to be 75 per cent to 85 per cent reliable in detecting intracranial tumors.

Aid in Differential Diagnosis

Brain scanning, however, may be useful also in differentiating between brain tumor and an acute stroke, and the list of other non-neoplastic lesions demonstrable by the brain scan has become extensive. In addition to primary and metastatic brain tumor localization, the scan may be useful with encephalomalacia, subdural hematoma, intracerebral hematoma, aneurysm, vascular malformation, granuloma, abscess and cerebral contusion. Even multiple sclerosis in the acute phase has been known to give a positive scan.

The accumulation of radioactivity at the abnormal intracranial site is not truly an uptake as in the case of iodine utilization by the thyroid. As currently conceived, there is a breakdown of the blood brain barrier, with subsequent accumulation of the radioactive substance at the abnormal site.

The lack of morbidity and the relatively low radiation exposure, especially when using the chlormerodrin form of radioactive mercury 197 (mercurial diuretic form of Hg.^{197}), allow performance of this study even on an outpatient basis.

Submitted to the Publication Committee, April 18, 1966.

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Numerous radioactive substances are useful in brain scanning but, currently, the most popular are chlormerodrin Hg.^{203} and chlormerodrin Hg.^{197}. Approximately one to two hours after the intravenous injection of 500 to 700 uc. (microuries) of chlormerodrin Hg.^{197} the scanning procedure is begun. In the case of chlormerodrin Hg.^{203}, with a physical half life of 47.9 days as compared with 2.7 days of Hg.^{197}, a 1 ml. intramuscular injection of nonradioactive Mercuhydrin (meralluride injection USP) is given the preceding day to reduce the radiation dose to the kidneys.

The dosage of chlormerodrin Hg.^{203} is 10 uc. per kilogram of body weight or a dose in the range of 500 to 700 uc.; but with chlormerodrin Hg.^{197} dosage varies from 500 uc. for children to 700 uc. for adults.

The following table lists the radiation dose:

	Whole Body	*Kidneys*
Chlormerodrin Hg.^{203}	0.290 r	30-40 r
Chlormerodrin Hg.^{197}	0.009-0.012 r	3-4 r

These radiation doses are considered acceptable for the diagnostic problem at hand and in

Figure 1

the younger patients chlormerodrin Hg.[197] is used because of its lower radiation dose to the patient.

Many commercial scanners are available. At West Virginia University Medical Center the PHO/DOT Isotope Scanner, manufactured by Nuclear-Chicago is employed (Figure 1).

The following cases illustrate some of our experience in radioisotope brain scanning.

Brain Tumor

The arteriogram generally is unsuccessful in demonstrating lesions in the posterior aspect of the brain because the carotid circulation is primarily anterior in distribution. The following case demonstrates the advantage of the brain scan in revealing the more posterior lesions.

A 69-year-old man had difficulty seeing to the left which resulted in his bumping into things when on foot and driving left of the center line when in his car. He had headaches also and clumsiness in the use of the left hand. The arteriogram was suggestive but not diagnostic of an occipital lobe mass (Figure 2 left). The brain scan (Figure 2 right)* very strikingly revealed a large occipito-parietal mass which proved to be glioblastoma multiforme.

The brain scan has proved consistently to be useful in demonstrating glioblastoma multiforme, meningioma and metastatic tumor. The following case concerns multiple lesions visualized by this means, only one of which was clearly revealed on the arteriogram.

A 56-year-old man was initially admitted for evaluation of focal seizures of recent onset. At this time an arteriogram and a pneumoencephalogram were normal. On readmission eight months later, the arteriogram (Figure 3 left) disclosed a right frontal lesion and was suggestive of a right parietal lesion as well. The brain scan (Figure 3 right) left no doubt that there were two lesions on the right and revealed a third mass on the left side.

More than once the brain scan has revealed completely unsuspected lesions.

A 63-year-old woman had a right retrobrachial arteriogram made for evaluation of two brief episodes of weakness of the left arm and leg which were thought to represent transient episodes of cerebral vascular insufficiency. The study (Figure 4 left) was entirely normal in all projections. A brain scan (Figure 4 right), however, showed a discrete abnormal focus of activity which, by its sharp borders and location, suggested a meningioma which was confirmed at operation. The diagnosis would not have been made if the brain scan had not been performed because ordinarily the work-up would have stopped with the normal arteriogram.

Lesions close to the midline, such as pituitary neoplasm, brain stem tumor and posterior fossa tumor ordinarily are not very well visualized on the brain scan. The following case of an acoustic neurinoma of the right cerebellopontine angle was nicely visualized on the brain scan.

A 62-year-old woman was referred for evaluation of headaches and blindness. Further history disclosed

*Scans are reprinted as overlays on the same patient's skull radiographs for purposes of demonstration.

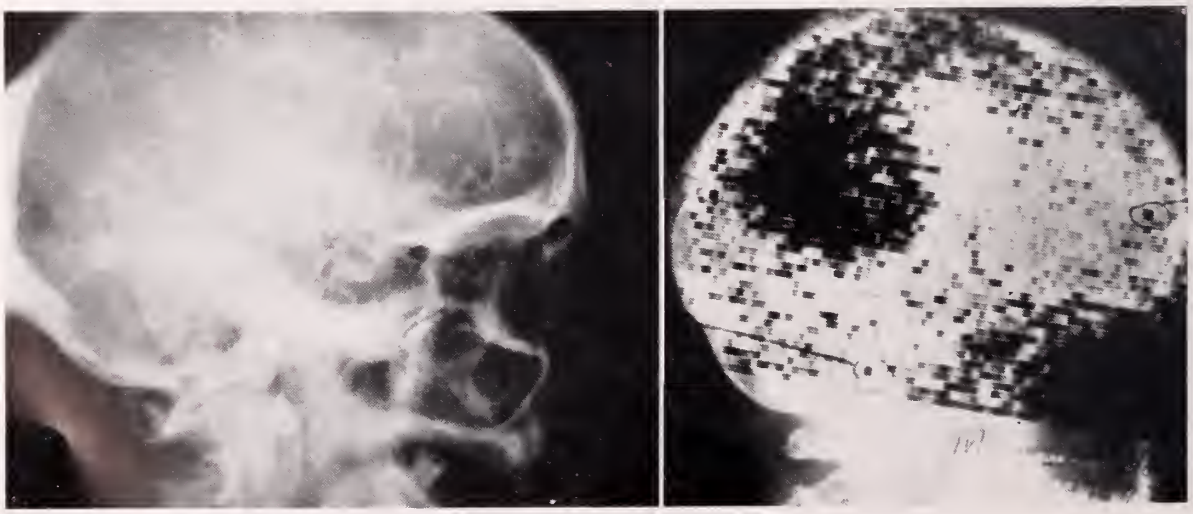

Figure 2

that in recent years deafness of the right ear had developed and there had been episodes of dizziness and unsteadiness. Examination disclosed severe bilateral papilledema, deafness on the right, nystagmus and absence of right corneal reflex. The brain scan (Figure 5) disclosed a mass in the posterior fossa on the right. A ventriculogram confirmed the mass which, at operation, proved to be an acoustic neurinoma.

Vascular Lesions

By virtue of the breakdown in the blood brain barrier caused by cerebral ischemia, the brain scan may clearly demonstrate areas of cerebral infarction. The abnormal focus of activity so produced usually clears in a few weeks.

A 53-year-old man had sudden onset of right-sided weakness and aphasia which proved by arteriography to be caused by complete occlusion of the left internal carotid artery. A brain scan (Figure 6 left) performed eight days after onset of his difficulty showed a well demarcated focus of radioactivity in the distribution of the middle cerebral artery. A repeat brain scan (Figure 6 right) four weeks later demonstrated complete clearing of the area.

A 37-year-old woman had fallen to the floor nine days before admission because of sudden onset of weakness of the left extremities. Bilateral arteriography showed no vascular abnormalities nor evidence of an intracranial mass. A pneumoencephalogram also was normal. A brain scan (Figure 7) definitely limited the trouble to distribution of the anterior cerebral artery on the right and thus implicated a vascular lesion. Further studies revealed lupus erythematosus and she certainly must have had cerebral arteritis, which may accompany this disease.

Intracranial Hematoma

A 58-year-old man had a brain scan performed for evaluation of headaches. The scan showed a relative increase in uptake over the right vertex in the anteroposterior scan (Figure 8 left) which raised the question of subdural hematoma on this side. The lateral scan was normal. An arteriogram (Figure 8 right) confirmed the subdural hematoma. This diagnosis most likely would not have been made if the brain scan had not been performed, because subdural hematoma was not suspected clinically and arteriography was not being considered.

We have also successfully demonstrated right temporal lobe traumatic intracerebral hematoma, with the brain scan.

Other Lesions

In addition to the above described lesions we have obtained a positive scan in the case of a

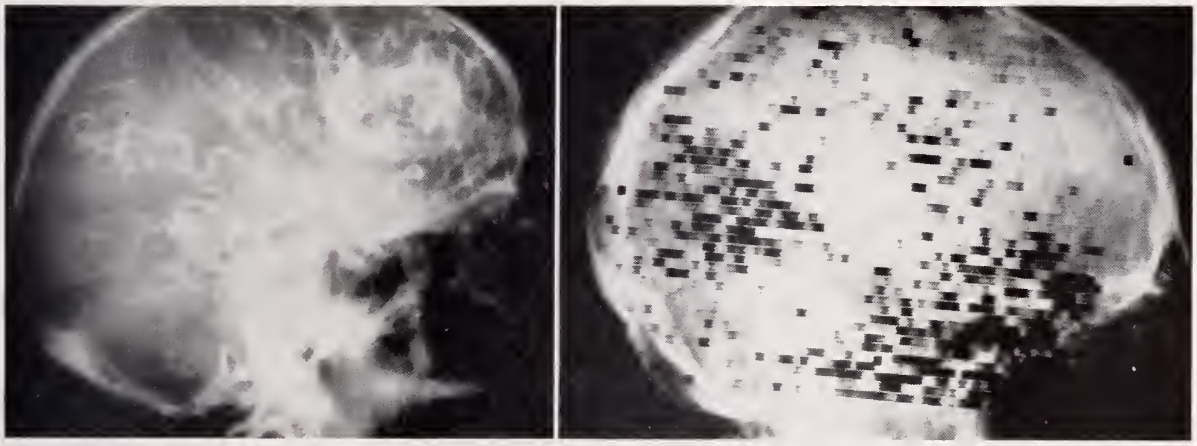

Figure 3

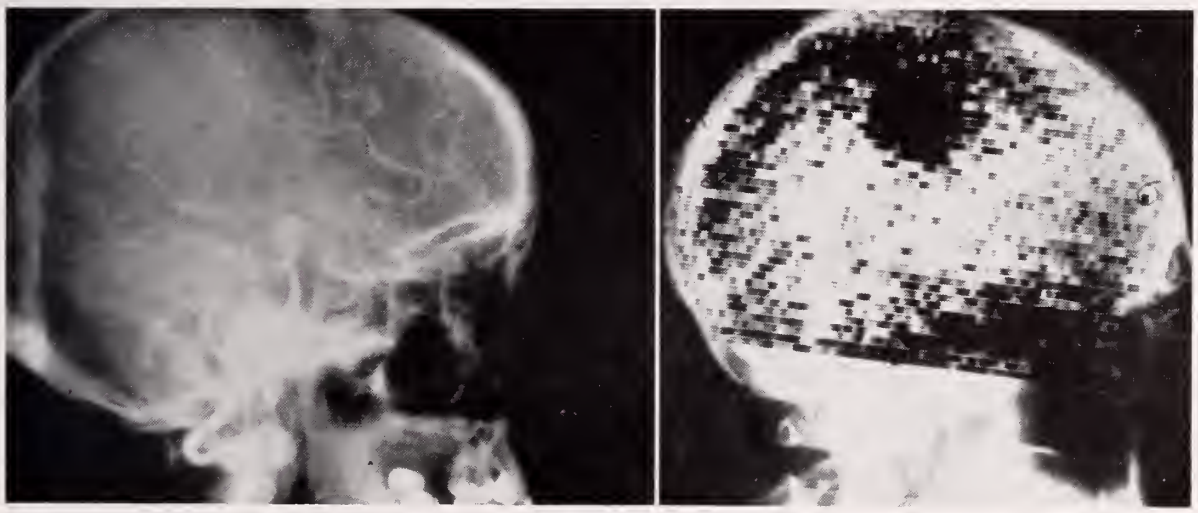

Figure 4

patient with right parietal lobe brain abscess and in the case of another patient with angiomatous malformation, also in the parietal region.

For the first time in many years a new, safe and extremely useful diagnostic procedure has entered the scene to supplement the time-proven procedures of electroencephalography, pneumoencephalography and arteriography. Although the present methods of brain scanning are practical and satisfactory, improvements will undoubtedly further simplify the technique. Certain centers are now using the isotope technetium 99m which, because of its short half-life, will permit obtaining the scan in approximately 10

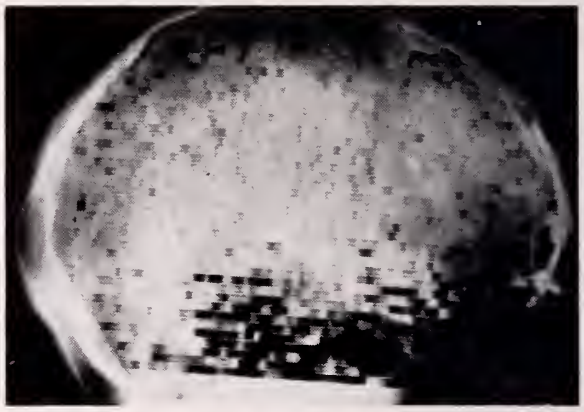

Figure 5

Figure 6

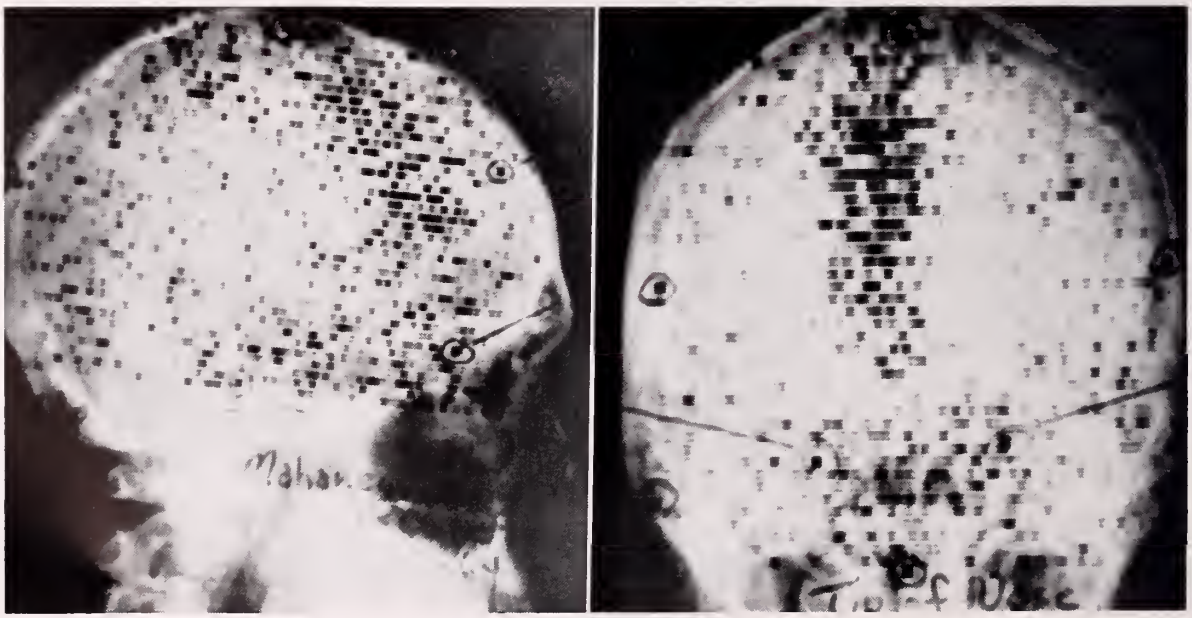

Figure 7

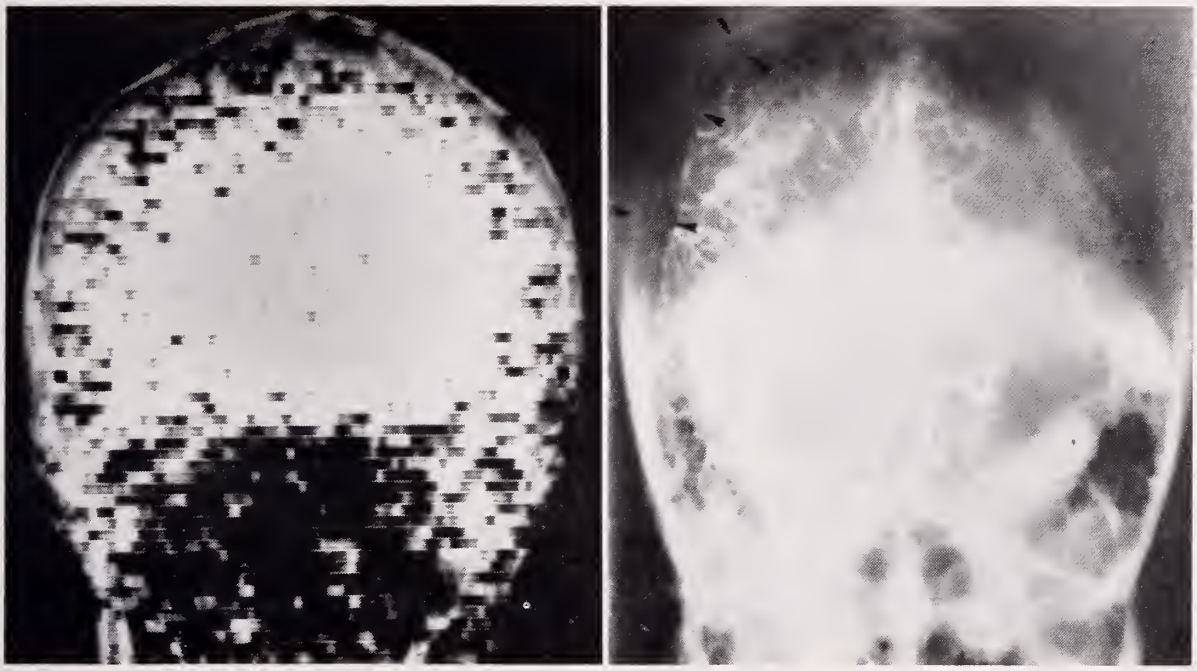

Figure 8

minutes and at the same time considerably decrease radiation exposure to the kidney.

Summary

The diagnostic value of radioisotope brain scanning is illustrated. Many different types of abnormality are demonstrated.

The lack of morbidity allows the method to serve as one of the screening procedures even on an outpatient status.

Acknowledgment

The authors acknowledge with thanks the help of Ellsworth J. Browning, B. S., who spent many hours preparing the illustrations.

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Brand or Generic—Let the Physician Decide

The generic name versus trade name has been and is one of those tiresome issues that never seems to get settled and is always good for a political "hoorah." As a physician, I have to prescribe drugs and my patients have to use and pay for them. Perhaps I have been too permissive, but I do not believe the cure is adoption of all generic names and federal control. I believe the problem is not all that complicated unless we prefer to make it so. Is it disrespectful to suggest that the decision should rest principally in the hands of the thoughtful physician? And you know there are some!—Irvine H. Page, M. D., in *Modern Medicine*.

against the usual gram-negative urinary pathogens

Why use five...where one will do?

In a recent 217-patient hospital study,[1] urinary tract infections were treated with a variety of widely prescribed antimicrobial agents including: a sulfonamide (40 patients), chloramphenicol (20 patients), nitrofurantoin (33 patients), nalidixic acid (30 patients), tetracycline (27 patients), colistimethate sodium (22 patients)...and 2 combinations of 5 agents each (45 patients). The 2 combinations were selected to afford maximal theoretical antibacterial coverage against the usual urinary pathogens. They were (1) tetracycline, chloramphenicol, nitrofurantoin, ristocetin and polymyxin B; and (2) tetracycline, chloramphenicol, erythromycin, nitrofurantoin and colistimethate sodium.

This clinical study shows that the two combinations of antibiotics were not superior to some of their single components. The authors point out that antibiotic antagonism often negates theoretical advantages of multiple therapy. Coly-Mycin Injectable (colistimethate sodium) was one of the single components that was shown to be equal to the combinations and eradicated bacteriuria in two-thirds of the patients.

Theoretical choice of multiple antibacterial therapy has been shown to be no more effective than one well-chosen agent which also offers least patient exposure to possible side reactions, toxicities, allergic manifestations and higher drug costs.

1. McCabe, W. R., and Jackson, G. G.: New England J. Med. *272*:1037, 1965.

in gram-negative urinary tract infections often the single well-chosen agent

Coly-Mycin® Injectable
(colistimethate sodium)

Indications: Especially indicated for the treatment of severe acute and resistant chronic urinary tract infections due to sensitive strains of gram-negative organisms. Also indicated in respiratory tract, surgical, wound and burn infections and in septicemia due to sensitive organisms. Particularly indicated when any of these infections are caused by sensitive strains of *Pseudomonas aeruginosa.*

Adverse Reactions: Occasional reactions such as circumoral paresthesias, tingling of the extremities, pruritus, vertigo or dizziness may occur. Reduction of dosage may alleviate symptoms. Therapy need not be discontinued, but such patients should be observed with extra care.

Warning: Patients should be cautioned not to drive vehicles or use hazardous machinery while on therapy.

Precautions: In cases of impaired or suspected renal impairment, use with greater caution and reduce dosage in proportion to extent of impairment. Transient elevations of BUN have been reported. As a routine precaution, appropriate blood studies should, therefore, be made during prolonged therapy.

As with all polypeptides, the possibility of muscular weakness, including apnea, due to inadvertent overdosage or normal dosage in the presence of impaired renal function, should not be overlooked. In cases of apnea, medication should be promptly discontinued and assisted respiration given until serum levels fall and normal breathing is restored.

Other antibiotics, such as kanamycin, streptomycin, dihydrostreptomycin, polymyxin, and neomycin, may also have varying neurotoxic or nephrotoxic potential. They should be used with great caution concomitantly with Coly-Mycin Injectable (colistimethate sodium).

For deep intramuscular injection only.

Dosage: By the I.M. route only, in 2 to 4 divided doses ranging from 1.5 to 5 mg./Kg./day (0.7 mg. to 2.3 mg./lb./day). Average adult dose is 2.5 mg./Kg./day (1.1 mg./lb./day). In the presence of bacteremia, septicemia, or other serious infection, greater than average doses may be required; however, maximum daily doses should not exceed 5 mg./Kg. (2.3 mg./lb.) where renal function is normal.

Not recommended against Proteus.

Colistin is also available (as colistin sulfate) in: Coly-Mycin® Pediatric for Oral Suspension (not for systemic use), and Coly-Mycin® Otic with Neomycin and Hydrocortisone.

Full information is available on request.

CI-CP-69-R2

WARNER-CHILCOTT Morris Plains, New Jersey

A Survey of North American Blastomycosis in West Virginia

Alfred K. Pfister, M. D., and Daniel Hamaty, M. D.

The epidemiology of North American blastomycosis is characterized as occurring sporadically with the exception of one epidemic.[1] The majority of cases are found in the eastern part of the United States and adjacent portions of the Midwest.[2]

The reported high prevalence of the disease in five of the six states surrounding West Virginia[2] and the occurrence of a fair number of cases at our hospital prompted a statewide survey to determine the pattern of this systemic fungal disorder in West Virginia. A form was sent out to the Record Librarian of every accredited hospital in the State requesting the name, age, sex, occupation and county of origin at the time of diagnosis, of patients in all cases coded as North American blastomycosis.

Questionnaires were mailed to 93 hospitals in the State. Of the 66 returned, only 13 reported cases listed in their hospital records. These hospitals reported 40 cases. Six institutions accounted for 32 of them.

Validity of the survey findings is influenced by the fact that, in general, reliance had to be placed upon Medical Record Librarians. In 27 cases, however, it was possible to examine either the records or the patients, or to consult the physician familiar with the case. Since the disease is uncommon and relatively unknown in West Virginia, overdiagnosis is considered unlikely.

Results and Comment

The 40 reported cases included 33 males and seven females. In 60 per cent, the disease occurred between the ages of 40 and 69. By decade the largest number of cases was in the 40-to-49-year age group; the average age for both sexes was slightly higher (Figure 1).

Occupational histories were classified into four groups (Table 1) for comparison with the findings of previous surveys[3, 4] which indicated a relation between the disease and those occupations allied with close contact with soil. In 75 per cent of cases in which an occupation was reported, the employment brought the patient into close contact with soil. The relation is further strengthened by the recent culture of the organism *Blastomyces dermatitides* from the soil.[5]

County distribution (Figure 2) shows most cases scattered in the southern part of the State, apparently independent of questionnaire response and population centers. Ohio, Cabell and Kanawha counties embrace approximately 23 per cent of the State's population but yielded only 12 per cent of the cases; on the other hand, Raleigh, Fayette and McDowell counties embrace only an approximate 12 per cent of the state's population and yielded over 40 per cent

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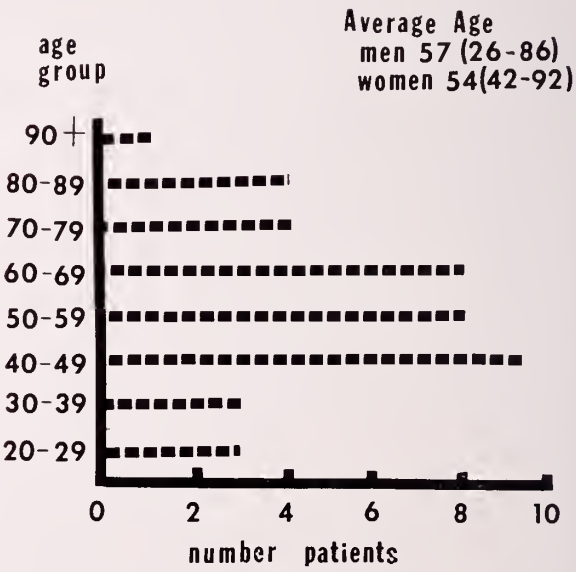

Figure 1

Age distribution 40 cases of North American blastomycosis.

Table 1

Occupational Histories of 40 Patients with North American Blastomycosis

Occupations	
Mining	15
Closely related to soil contact	6
Not closely related to soil contact	7
Unemployed or not stated	12

of the cases. It is merely speculative whether or not the occupational differences of urban life and more rural areas can account for this distribution. The lack of cases in the northern and eastern parts of the state could well be due to referral to medical centers outside the state.

The mode of transmission and the nature of the susceptible population to *Blastomyces dermatitides* are not completely understood. The organism appears to have a low degree infectiousness; there is only one recorded instance of the disease occurring in siblings.[1]

The skin test and the complement fixation test are not reliable in conducting surveys for North American blastomycosis. An organized registry in every state would furnish a more effective means of determining the epidemiology and natural history of the disorder. It is of interest that a fair number of patients in our survey had seen thoracic surgeons or dermatologists before the diagnosis was made. In other instances the diagnosis of blastomycosis was made after specimens of suspected cutaneous malignancies were sent to the pathologist. Perhaps our survey or other surveys could be supplemented effectively by the use of questionnaires directed to those specialists.

Summary

A statewide survey was made to determine the prevalence of North American blastomycosis in West Virginia. The results showed that infected persons frequently had occupations allied with close contact with the soil. Prevalence of the disease in West Virginia apparently approximates that found in the neighboring states.

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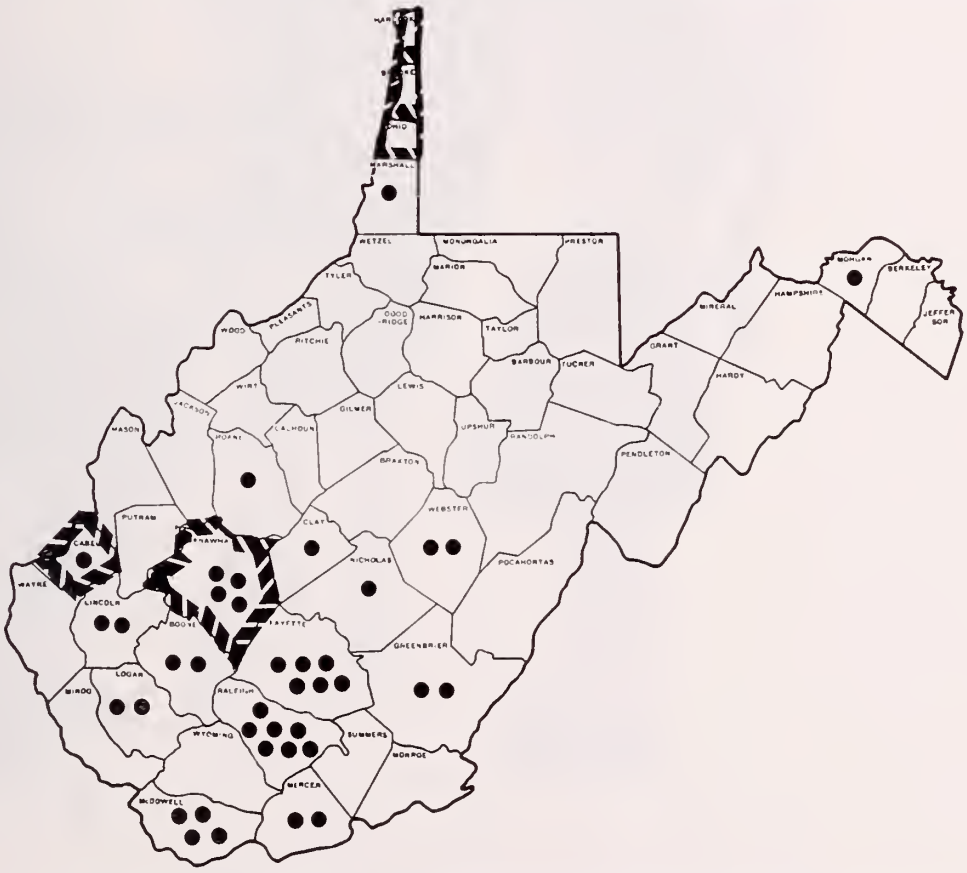

Figure 2

Each dot represents one case of North American blastomycosis in the county of origin. Counties outlined represent population density of over 250 persons per square mile.

Well, Doctor, it's sort of
a cross between a smoker's hack and a seal's bark.

It's a wise mother who realizes there may be more to her child's cough than meets the ear —and brings the youngster to you promptly for diagnosis and treatment.

If the cough is the useless, exhausting type that often accompanies respiratory infection or allergy, you can provide prompt relief with Novahistine DH. Its decongestant-antitussive action controls frequency and intensity of cough spasms without abolishing cough reflex. And the fresh grape flavor of Novahistine DH appeals to children and adults alike.

When your diagnosis is bronchitis, complicated by thick tenacious exudates, Novahistine Expectorant is particularly useful. It not only provides decongestive action and controls the cough, but also encourages expectoration, thus easing bronchial constriction and obstruction.

Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Ambulatory patients should be advised that drowsiness may result. Continuous dosage over an extended period is contraindicated since codeine phosphate may cause addiction.

Each 5 ml. teaspoonful of Novahistine DH contains codeine phosphate, 10 mg. (Warning: may be habit forming); phenylephrine hydrochloride, 10 mg.; chlorpheniramine maleate, 2 mg.; chloroform (approx.), 13.5 mg.; l-menthol, 1 mg. (Alcohol 5%). Each 5 ml. of Novahistine Expectorant contains the above ingredients and, in addition, glyceryl guaiacolate, 100 mg.

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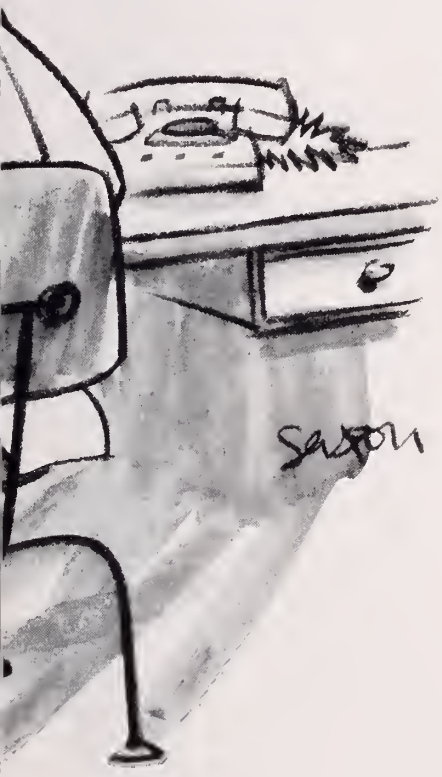

Ventricular Fibrillation Following Cardioversion

William S. Sheils, M. D.

SINCE its introduction by Lown,[1] in 1962, "cardioversion" has become a widely accepted means of treating atrial fibrillation. The early reports of its safety and effectiveness have been tempered by experience, as complications of the procedure are reported.

Following is the report of a case in which ventricular fibrillation developed following electrical discharge which occurred during the vulnerable phase, despite adequate pre-shock synchronization of the electrical discharge to the R wave.

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Case Report

A 51-year-old white male had known he had heart disease since the age of 22, following routine examination for the Armed Forces. Symptoms of heart failure had begun seven months before his admission on September 23, 1964, and had progressed from mild exertional dyspnea to orthopnea and paroxysmal nocturnal dyspnea. On September 21, 1964, while on a hunting trip, severe shortness of breath developed, associated with substernal chest pain which radiated into the left arm. The pain was increased by exercise and subsided on rest.

Physical examination: Blood pressure 120/50 mm. Hg., Pulse 160 per minute, and irregular. Respiration 25 per minute. Temperature 99.6 F. He was a well developed, well nourished, white male in acute respiratory distress. The skin was cool and clammy, but not cyanotic. Examination of the head, ears, eyes, nose and throat was negative. The jugular venous pressure was increased. The carotid pulsations were normal. Medium moist rales were present in both lung bases, associated with hyperpnea and prolongation of the expiratory phase. The point of maximal cardiac impulse was 1 cm. outside the midclavicular line in the sixth intercostal space. The heart rhythm was rapid and irregular. There was a grade 2/6 systolic ejection murmur heard over the entire precordium. No other murmurs were heard. The liver was palpable three fingerbreadths below the right costal margin. There was no ankle edema. The peripheral pulses were normal.

Electrocardiogram revealed atrial fibrillation with a rapid ventricular response, left ventricular hypertrophy, and a questionable old anterior septal infarction. Repeat electrocardiograms did not reveal evidence of acute myocardial injury. X-ray of the chest showed moderate cardiomegaly with evidence of congestive heart failure.

Laboratory examination: Hemoglobin 12.8 gm. per cent. White blood count 10,700 per mm.^{3} with 65 per cent neutrophils. SGOT 39 units on the first hospital day, rising to 70 units on the second day. Corrected sedimentation rate 12 mm. Urinalysis negative. Blood urea nitrogen 20 mg. per cent. PBI 5.3 migrograms per cent. Blood culture negative on two occasions.

Hospital course: The patient was digitalized with digoxin and was given hydrochlorothiazide and potassium gluconate. His symptoms subsided rapidly, and on the third hospital day a diastolic murmur was heard along the left sternal border. Four days later an apical diastolic rumble also could be heard.

A clinical diagnosis of rheumatic heart disease with aortic insufficiency and mitral stenosis with atrial fibrillation was made. On admission, he was functional Class IV.

On the 11th hospital day, he was given quinidine sulfate 200 mg. every six hours in preparation of cardioversion. On the following day, following intravenous thiopenthal anesthesia, an attempt at cardioversion was made. Prior to anesthesia, the discharge was repeatedly synchronized with the peak of the R wave. The electrodes were placed over the base and apex of the heart, and a discharge of 100 watt seconds was delivered. The electrocardiogram immediately revealed ventricular fibrillation (Figure 1). The synchronizer switch was turned off, and three attempts at converting this rhythm with maximal voltage (300 watt seconds) was made before defibrillation could be attained. A sinus rhythm developed, with intermittent bursts of ventricular tachycardia for the next 30 sec-

Submitted to the Publication Committee, April 8, 1966.

onds (Figure 2). Quinidine gluconate 500 mg. was given intramuscularly. Approximately one minute after the defibrillation, the patient failed to show any further ectopic activity and has continued in sinus rhythm for 15 months.

*American Optical Cardioverter (Lown).

Serial electrocardiograms following cardioversion did not show acute myocardial damage, but the P waves had the configuration of P mitrale.

He is being maintained on digoxin, 0.25 mg. twice a day and quinidine sulfate, 200 mg. every six hours.

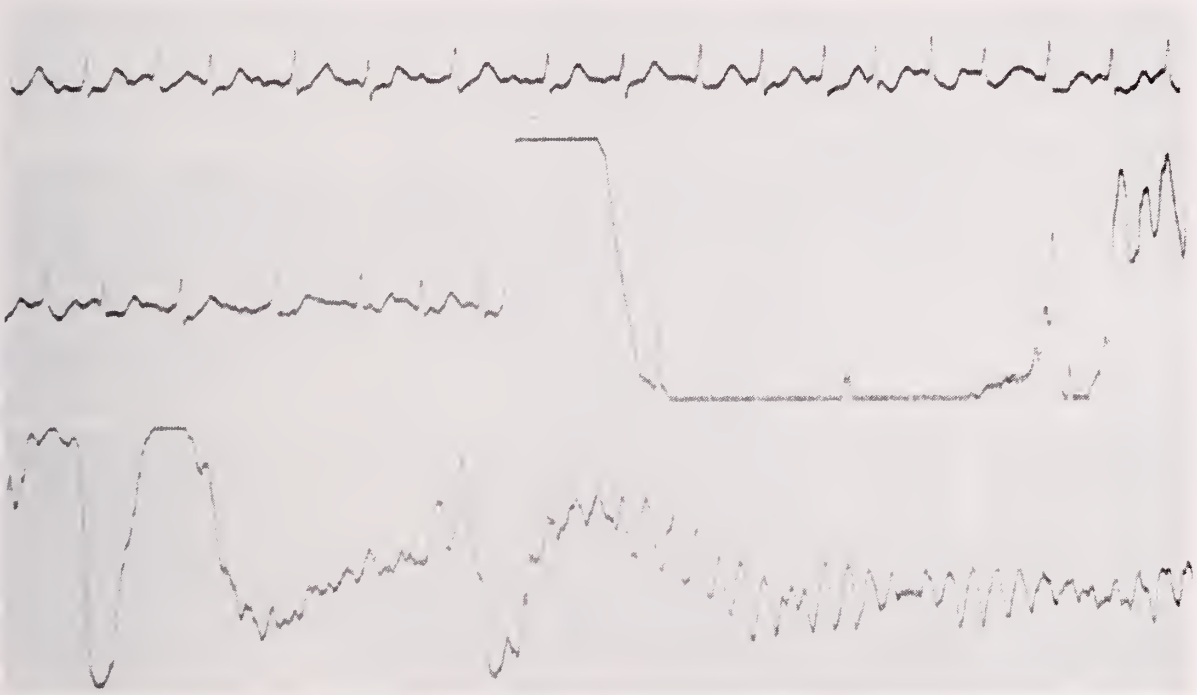

Figure 1. Continuous tracing showing discharge occurring during rapid upstroke of T wave with resultant ventricular fibrillation. Note that the upstroke of this T wave is more rapid than any other T wave.

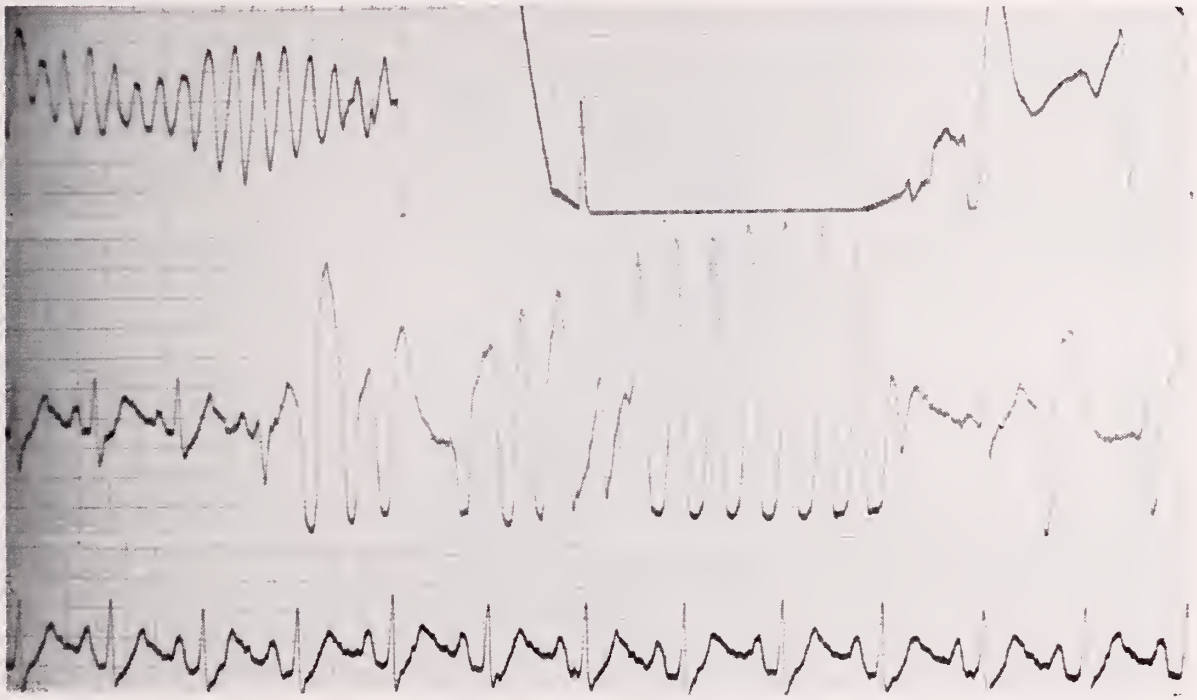

Figure 2. Termination of ventricular fibrillation by counter-shock. Note burst of ventricular tachycardia in middle strip.

Discussion

The threat of ventricular fibrillation is always present with cardioversion. Rabbino[2] et al reported a significant number of patients with delayed onset of ventricular fibrillation, despite synchronization of the shock with the R wave. Our case represents a different hazard; the premature discharge of shock as a result of a changing slope of the T wave. A rapid upsweep of the T wave could result from a superimposed F wave upon the T wave, or a sharply wandering base line from sudden pressure of the electrodes on the chest.

Any artifact of the base line causing a rapid upsweep could activate the synchronizer. Discharge of the current during the vulnerable phase may also occur if the synchronizer is timed to a positive QRS wave deflection when the QRS wave form shows predominately a QS form in presence of an upright peaked T wave.

Our experience has resulted in the following precautions during cardioversion:

(1) Particular care is taken to secure the monitoring electrodes to the patient in order to minimize loose electrode artifact.

(2) Routine electrocardiogram (lead 2) is taken before, during, and after shock.

(3) The polarity switch is turned to positive (+) if the major QRS depletion is upright; or negative (−) if the major deflection is downward.

(4) Permanent electrocardiographic confirmation of the accuracy of the synchronizer is made prior to each attempt. The electrode paddles are coated with electrode jelly and placed in opposition to each other and a test fire of 30 watt seconds delivered. The recommended test discharge of 10 watt seconds is frequently insufficient to cause a "blip" to be written on the tracing.

(5) The sensitivity switch is set at the lowest setting possible to activate the pulse rate monitor.

(6) The precordial electrodes are placed gently, but firmly, on chest wall.

(7) The base line must be stable prior to firing.

Summary

A case of ventricular fibrillation following cardioversion of atrial fibrillation is presented. With adequate pre-shock synchronization, the discharge occurred during the vulnerable period due to an artifact in the base line. Methods of prevention of this complication are outlined.

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Requests for reprints should be sent to William S. Sheils, M. D., Cabell-Huntington Hospital, Huntington, W. Va.

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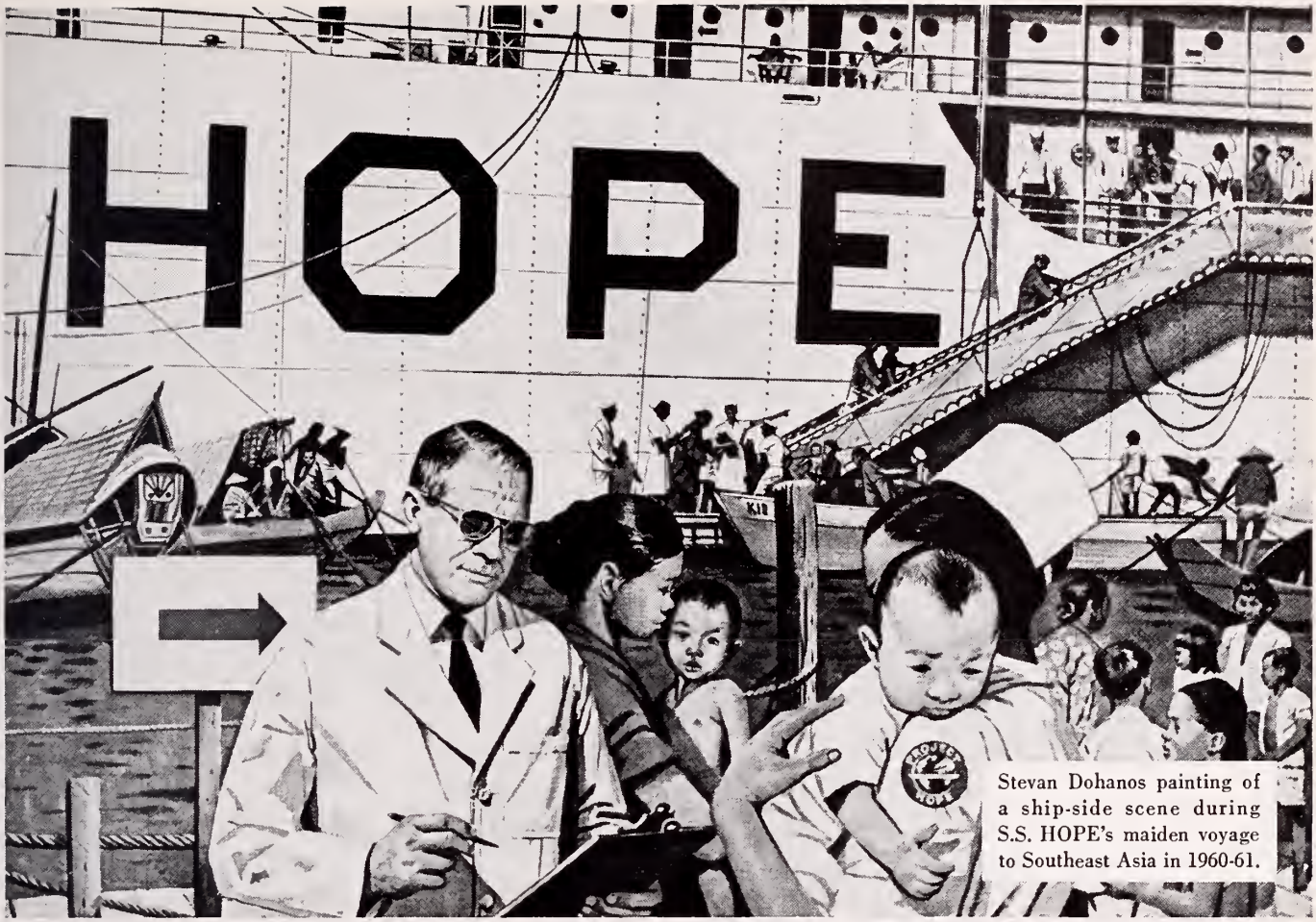

Stevan Dohanos painting of a ship-side scene during S.S. HOPE's maiden voyage to Southeast Asia in 1960-61.

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A message from . . .

The President

A CHEERY AND HOLY HOLIDAY SEASON

THIS being that time of year when all should be full of good cheer and kindnesses, let me say all hatred should be put aside—*not* for this particular time but for *all* times, and by *everyone.*

I had a very pleasant visit to Hancock County and the trip was a *short* one. We all gathered for a delightful time, wives included, and much interest was generated in the beginning history of our Association. George Evans, et al, did an excellent job in the November *Journal*, as he always does, and anyone who can contribute to his task please step forward and speak.

Ran into Al Esposito at the Notre Dame-Pitt game and both of us were shocked and pleased that he had found someone else born on 9 November—the year doesn't really matter!

On the memorable date just mentioned I was in Logan to meet with that Society. Many thanks to Tom Long and his group. It certainly is nice to visit an area and meet so many good old friends and to make so many new acquaintances. An enjoyable, happy birthday for me.

The Medical Education Planning Conference was held in Charleston on 13 November—the same day Ohio Valley General Hospital in Wheeling had its meeting. I trust conflicts of meetings may be avoided in the future by clearing all such meetings with the state office.

Merry Christmas to all of you; to the state office of Mary, Judy, Bill and Ed; to my office of Cope, Carole, Dorothy; to Robert; and to my family of Mom, Mildred, Estelle, Mary, Maura and Bill; and a HAPPY, HAPPY NEW YEAR TO EVERYONE.

RICHARD E. FLOOD, M. D., *President*

THE WEST VIRGINIA MEDICAL JOURNAL

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EDITORIALS

BLAME THE WORLD

According to a letter published in my newspaper, Charlie Griper (real name withheld) with his stomach falling out, was refused admittance to a West Virginia hospital because he could make no deposit.

After interviewing Charlie and the welfare official who he claimed had refused to help him, I discovered that this man constantly plagued the DPA office, was a malingerer, and had been a burden to them for years. He was not very sick at all.

I do not pretend that this story is typical of patients denied admission to hospitals for lack of money. Nor do I accept as general, or even frequent, the practice of hospitals to refuse sick people entrance for financial reasons.

Furthermore, the inclination of the public to blame doctors collectively for whatever failures do occur is probably very unjust.

Over the years I have had good reason to hear the doctor's side of the doctor-patient-dollar relationship. I have four brothers-in-law who are doctors and a sister who is a registered nurse. One of my college roommates removed Cassius Clay's appendix last year. My partner in raising horses is a doctor.

In addition to serving on our county Board of Health for 8 years, I have argued with and listened to the pleas of innocence and explanations of many West Virginia physicians, some of them my closest friends.

As in the case of most disagreements which occur between individuals and groups, there is common misunderstanding by laymen of the truths and trends of the medical profession. The problems of the modern hospital are compounded with these. Here are a few facts which those of us who have no one's health but our own to worry about should consider before we damn doctors:

Every doctor admits that there is an average number of their profession who are unscrupulous, indifferent, and greedy. They are not typical and the profession should not be judged by its rotten apples.

Most hospitals, or regional medical societies, make some kind of an effort to curb unethical practices within their spheres of influence. This self-policing, which is not new, is almost unique on the American social scene.

People become patients when they are sick. In this frequently desperate condition, often as helpless as innocent children, they are uniformly demanding of the doctor that he save their everything. Most are hardly psychologically fit to

judge the physical or moral values of their treatment. They see doctors when they themselves are the most unreasonable and selfish. The doctor is soon forgotten after health has been restored.

Too many of us, whose only contribution to medicine and community health is a sick body, turn the green eye upon doctors because most earn a lot of money. For some reason we expect them to be money-shunning martyrs while we pursue Mammon.

Doctors do constitute the highest income group in the country, but of all the people I know, it is they whom I would most happily reward for their contribution to humanity. About the only way society knows to pay is with cash.

Yet his over-all income is an unfair yardstick by which to measure a doctor's deserts, for the sacrifices of the average doctor surpass those of a dozen ordinary citizens. His occupation helping the sick, mending smelly and broken bodies, glimpsing naked souls—is one from which most of us would flee in a second.

Conscientious doctors have no home life, as most of us crave. While we sleep, work regular hours, and play, they hold office hours, make hospital calls, and depending upon their practice, are frequently called from their beds at night. Much of their lives they share with us.

No doctor with whom I have talked can remember a specific instance of a hospital's deliberately and indifferently failing to admit an emergency patient for lack of funds.

It takes courage to become a doctor in the first place.

The most difficult fact for the public to comprehend seems to be that hospitals are no longer operated by doctors. Of old the family doctor attended his patients, sent them to a private hospital where the surgeon was a personal friend. Discussion of money would have been a breach of etiquette. Eventually a bill came the size of which was a matter of the doctor's discretion.

All of that has changed. Most hospitals of today are publicly, or semi-publicly, owned and operated. Within them doctors fulfill a function at the top level but much as the janitor and the receptionist. The hospital administration furnishes them with patients and equipment. Hospital policies and charges are determined by boards of directors often as remote from the actual practice of medicine as if they produced steel.

Whatever doctors are and become is and will be the result of how our growing and changing society molds them today and tomorow. The more it strips doctors of their professional identity the less it can blame them for the indifference of modern medicine. Blame the world for being the way it is.

(This article not paid for by the American Medical Assn.)

Editor's Note: This article by Mr. Ed White appeared in the *Charleston Sunday Gazette-Mail.*

NORTH AMERICAN BLASTOMYCOSIS

The article elsewhere in this issue on "A Survey of North American Blastomycosis in West Virginia" by Pfister and Hamaty is most timely. The protein manifestations of infections with the fungus, *Blastomyces dermatitidis,* place this disease with tuberculosis and syphilis and Osler's "Great Imitators." The ability of this disease to mimic tuberculosis, lung cancer, pneumonia, lung abscess, skin cancer, bromoderma, bone abscess, Pott's disease, meningitis, brain abscess, etc., to name only a few, facilitates a mistaken diagnosis and improper treatment. To diagnose blastomycosis one must first think of the disease as a possible etiology.

Pfister and Hamaty show that blastomycosis is present in West Virginia in significant numbers. Their survey revealed 40 cases in hospitals within the State. At least 11 additional cases are known to have been diagnosed in out-of-state hospitals, raising the total number of cases to 51 in West Virginia. In adjacent states, Kentucky is known to have at least 147 human cases and 34 canine cases; Tennessee, 105 human and 10 canine cases; and Virginia, 18 human and one canine cases. Ohio and Pennsylvania have eight and five human cases, respectively, and a similar number of canine cases.

Does this mean that there is a sharp geographic distribution of the disease, or are these differences related to awareness and diagnosis? At this point no one knows. Antigens are not suitable for the large skin test surveys that have elucidated the distribution of histoplasmosis and coccidioidomycosis. This means that knowledge of blastomycosis and its distribution must come from diagnosed cases. It is to be hoped that Pfister and Hamaty's article will increase awareness and stimulate an interest in this disease in West Virginia, and that some way will be found to implement their suggestion of some form of central registering of cases of blastomycosis as they occur.—*Guest Editorial by Ernest W. Chick, M. D.*

GENERAL NEWS

Community Health Week Observed In Weirton

Weirton and Hancock County have received national publicity in American Medical Association publications for their Community Health Week observance, which was held during the week of October 17.

The Weirton-Hancock observance was one of a few held this year in various parts of the nation.

The following story was prepared for *The Journal* by Miss May Nazar of Weirton:

Community Health Week was observed in Weirton with a Health Fair which was one of the few sponsored on such a scale in the United States.

Dr. Ray S. Greco was Chairman, and he and representatives of the various health professions and related organizations knitted together a wide range of projects for the first fair of its kind ever held in the community.

The four and a half day program was put on by the Hancock County Medical Society, the Hancock Dental Society, all health service agencies and departments of the area and the Weirton General Hospital staff.

Exhibits, films, demonstrations and workshops and a number of free health tests were offered to the public by the personnel of the hospital, local doctors and members of the various health professions in the community.

4,000 Persons Attend

The fair attracted 4.000 adults and students. Several area policemen, firemen, state troopers, Weirton Steel Safety Department personnel, the Civil Air Patrol, ambulance drivers and school personnel attended the emergency transport workshop. It was conducted by Dr. Howard Brettell of Steubenville, Ohio. It dealt with the emergency care and transportation of the sick and injured. An emergency vehicle, operated by a local volunteer fire department and fully equipped, was on display at the hospital grounds.

One hundred persons attended the two diabetic workshops held in the hospital. Films were shown and a physician was on hand to answer questions on both days. Free blood samples were taken at a booth sponsored by the Department of Laboratories at the hospital and the blood was tested for sugar content.

Mayor Frank Rybka of Weirton cuts a ribbon at Weirton General Hospital marking the opening of Community Health Week in that city. Looking on (from left to right) are: Dr. Ray S. Greco, Community Health Week Chairman; Mr. Norman Budde of the American Medical Association; Dr. Eli J. Weller, President of the Hancock County Medical Society; Miss Juliann Ritter, Executive Secretary of the West Virginia Nurses Association; and Mr. Charles Okey, Hospital Administrator.

A total of 640 persons received the Wright Peak Flow Meter Test given at the booth sponsored by the Hancock County Tuberculosis League. The test was to measure breathing capacity and detect obstructions to breathing.

Blood tests were administered to 302 persons at the Department of Laboratories booth.

Eye tests were given to some 600 persons.

Free tetanus boosters were given to adults at the mobile examination unit, displayed and operated by the Division of Maternal and Child Health of the State Health Department.

Booths and Exhibits

There were 22 booths and numerous other exhibits at the fair. Six films were shown on rehabilitation of crippled children, the heart, nutrition, mental health, cancer and lung diseases.

Junior and senior high school students were transported to the fair with a two-fold purpose—to acquaint them with health programs and modern medicinal advancement and to interest them in the field of public health and medicine.

Ribbon Cutting

A ribbon-cutting ceremony was held October 17 with representatives of national, state and county medical associations and members of local volunteer health and other organizations participating. Among those attending were Norman Budde of Chicago, a staff member of the Communications Division of the American Medical Association; Edward D. Hagan of Charleston, representing the West Virginia State Medical Association, and Miss Juliann Ritter of Charleston, Executive Director of the West Virginia State Nurses Association.

Mayor Frank Rybka of Weirton cut the ribbon marking the opening of the exhibit area.

Mrs. Greco was in charge of the hostesses who were comprised of members of the auxiliaries of the medical, pharmaceutical and dental societies of the area.

Miss Juliann Ritter, Executive Director of the West Virginia Nurses Association, receives some literature from Dr. Ray S. Greco at the Community Health Week exhibit of the West Virginia State Medical Association and the West Virginia Chapter, American Academy of General Practice, at Weirton General Hospital.

Rural Emergency Care Plan Proposed by AMA

The American Medical Association's Council on Rural Health has offered a five-point program for improving emergency medical care in rural areas.

As outlined by the Council, the program in particular stresses wider first aid training for rural Americans and swifter handling of emergency victims.

Bond L. Bible, Ph.D., Secretary of the Council, pointed out that a study of traffic fatalities indicates that "people injured in rural counties were almost four times as likely to die of their injuries as those injured in urban counties, despite the occurrence of less severe accidents and more survivable injuries."

"The higher case fatality ratio in rural areas seems to be related to the inability to provide adequate first aid procedures and to get the person to a hospital within a reasonable period of time," Doctor Bible said.

"In addition to motorists, emergency medical transportation and first aid arrangements are also highly important to farm families," he continued. "The National Safety Council reports that 740,000 disabling injuries occurred on farms during 1965 and that farming ranks third behind mining and construction jobs in accidental death rates."

The Rural Health Council's program, approved by the AMA Board of Trustees, urges that:

1. Rural communities coordinate their efforts with adjacent towns or urban centers in analyzing existing patterns of response to medical emergencies.

2. Rural and urban communities institute a medical service area program for emergency medical transportation facilities and health personnel.

3. Rural and urban communities, where possible, adopt the model ambulance ordinance to give the public a greater voice in the quality of ambulance care. (The ordinance proposes standards for ambulance equipment, personnel and operation, liability insurance requirements, maintenance of records, duties of regulatory agencies, and penalties to be imposed if the ordinance is disobeyed.)

4. Rural and urban communities provide a program of advanced Red Cross first aid instruction for the non-medical people most frequently called in rural emergencies—especially police, sheriffs, and ambulance crews.

5. Rural and urban communities develop a continuing campaign directed toward first aid instruction for rural families and particularly young people through the schools, youth organizations, and other educational channels.

Tenth Annual Cardiac Symposium

The Arizona Heart Association will conduct its 10th Annual Cardiac Symposium in Phoenix, Arizona, February 10-11, 1967.

Registration fees are $10 for one day, or $15 for both days.

Additional information and registration forms may be obtained by writing to the Arizona Heart Association, 1720 East McDowell Road, Phoenix, Arizona 85006.

Mrs. Fultz Re-elected President Of Nurses' Association

Mrs. Josephine Fultz of Clarksburg was re-elected President of the West Virginia Nurses Association during the annual meeting of that organization in Charleston, October 26-28.

Miss Nancy Martin of Moundsville also was re-elected First Vice President and Miss Cecilia Coyne of Bridgeport, Ohio, was named Second Vice President. Miss Audrey Windemuth of Morgantown was elected Secretary and Miss Dorthea L. Fee of Charleston was re-elected Treasurer.

Members of the Board for the coming year are Mrs. Rachel Collins of Elkins, Sister Andrea Novak of Clarksburg, Mrs. Ardenia Tully of South Charleston, and Mrs. Bernice Vance of Clarksburg.

Symposium on Forensic Medicine

The Mound Park Hospital Foundation will sponsor a symposium on "Forensic Medicine: The Doctor and the Law" in St. Petersburg, Florida, January 12-14, 1967.

Additional information may be obtained by writing to: Forensic Medicine, Mound Park Hospital Foundation, Inc., St. Petersburg, Florida 33701.

W. Va. University Receives Cancer Grant

Dr. David B. Gray of Charleston, President of the West Virginia Division of the American Cancer Society, has announced a $17,500 Institutional Research Grant to West Virginia University.

Dr. Alvin L. Watne is Chairman of the University's Institutional Research Grant Committee and is recipient of the grant.

The American Cancer Society seeks to encourage new minds and new ideas to enter cancer research through its program of Institutional Research Grants.

W. Va. Assn. of Pathologists Elects Dr. Ladewig

Dr. Peter Ladewig of Charleston was elected President of the West Virginia Association of Pathologists during a recent meeting.

Dr. Wilhelm S. Albrink of Morgantown was named Vice President and Dr. Dennis S. O'Connor was named to another term as Secretary-Treasurer.

Doctor Albrink and Dr. Werner O. Laqueur of Beckley are new members of the Board of Directors.

The Cabell County Medical Society sponsored a symposium on "Recent Trends in Diabetes" in Huntington on October 15. Speakers included (left to right): Dr. John C. Floyd, Associate Professor of Medicine at the University of Michigan; Dr. Edwin G. Beven, Department of Vascular Surgery, The Cleveland Clinic; Dr. George J. Hamwi, Professor of Medicine, Ohio State University; and Dr. Leo Krall of the Harvard Medical School. Also pictured are Dr. Joseph M. Farrell, President of the Cabell County Medical Society (far right), and Dr. D. A. Haught of Huntington (next to Doctor Farrell), Chairman of the symposium.

The Medical Society of West Virginia
1867-1874

As we approach the 100th anniversary of our West Virginia State Medical Association, we peer again into the past—100 years ago when organized medicine in our State was but an embryo.

In the pages that follow, the second installment of a *Journal* series, we take a look at the first seven annual meetings of the Medical Society of West Virginia, the forerunner of our modern State Medical Association. The information for this month's report has been gleaned from an old copy of the 1874 cumulative transactions of the Society.

There are some gaps in our history about which little or nothing is known, but in the months ahead, we plan to present to our readers as complete and concise a history of the Association as we possibly can.—The Publication Committee.

The Medical Society of West Virginia adopted the Code of Ethics of the American Medical Association at its first session in 1867. The Code is long and covers every possible contingency of professional conduct. In Article 1, Chapter 1, the Code states, "A physician should not only be ever ready to obey the calls of the sick, but his mind ought also, to be imbued with the greatness of his mission and the responsibility he habitually incurrs in its discharge."

Chapter 1 of the Code concerned the duties of a physician to his patients and the obligation of patients to their physicians. Chapter 2 defined the duties of physicians to each other and to the profession at large. This section contained detailed instruction concerning consultations, interference and conflict of interest. In Chapter 3, the articles pertained to the duties of the profession to the public and obligations of the public to the physicians.

After the first effort, the semiannual meetings ceased to be and the first annual meeting was held in Grafton, April 1-2, 1868. Dr. John Frissell of Wheeling was in the chair and 26 members were present. Perchance it was the beginning of a pattern, but most committee chairmen were not able or ready to report on their assigned subjects and this occasioned some trite remarks from the presiding officer. The President also chided designated speakers who failed to deliver their essays on assigned subjects.

A uniform rate of fee was recommended and a committee was appointed to prepare a bill for the entire profession of the state. (This report is still incomplete). Dr. H. W. Brock of Morgantown was now elected President. Seven delegates to the AMA meeting in Washington were elected and Clarksburg was chosen as the site of the next, or second, annual meeting. Again the Baltimore and Ohio railroad remitted the traveling expenses of the members present at the convention.

The proceedings were to be published in the daily Wheeling Intelligencer and one copy forwarded to each member. A new Constitution and By-Laws were adopted and a new publication committee was instructed to prepare and publish not only the proceedings, but all those essays, reports and communications worthy of publication under the title, "Transactions of The Medical Society of the State of West Virginia."

We now had 68 members. Truly, this was a society of Northern West Virginia. The most southernly inhabitants were members from Parkersburg and Wirt Court House.

President Frissell had an exceptionally lengthy address, but it reads well from begining to end. The address does clear one disputed point, to wit: "I am truly thankful to the society for their kindness in selecting me as their first presiding officer."

The closing paragraph is prophetic: "I hope that we shall all feel a pride in so conducting the affairs of the Society, that after a century has passed by, and they look over the books and musty pamphlets of olden time they will be constrained to say that the founders of the Medical Society of West Virginia were wise and good men, that they inculcated sound doctrines in medicine and morals and deserve to be remembered among the benefactors of the human family."

* * * *

The second annual meeting was held in the Methodist Episcopal Church in Clarksburg, June 2-3, 1869. Evidently the Committee on Publications had been admonished, because the reporting now takes on a more complete outlook. Twenty-two members were present. Doctor Brock's official address would fill and overflow the scientific section of a 1966 Journal.

There was considerable discussion over county medical societies. There was no provision in the Constitution and By-Laws at this time for such a situation. Nevertheless, at this Clarksburg meeting, a copy of the Constitution and By-Laws of the Medical Society of the City of Wheeling and the County of Ohio were presented to the Society. There was also a

society in Wood County. The "two societies were reported to this society as auxiliary." There were excellent reports on "The Medical Botany of the State, Climatology and Epidemics, Necrology, Publication and Recent Medical and Surgical Appliances."

Questions for discussion at the next meeting were selected and were well oriented for 1868. The topics were: "Is Child Bed Fever an Inflammatory Disease?" and "Is Phthisis Pulmonalis Curable?"

The report on the Topography, Meteorology and Climatology and Epidemic Diseases of Ohio County, West Virginia, is a masterpiece. The punch line at the end is, "I think its salubrity (Ohio County) and ratio of mortality will compare very favorably with any equal portion of territory between the Atlantic and Pacific Oceans," so said E. H. Hildreth, M. D.

* * * *

The third annual meeting of the society was held in Parkersburg, June 1-2, 1870. Dr. J. A. Ramsey of Clarksburg, the President, was not present and the Vice President, Dr. E. A. Hildreth of Wheeling was in the chair. Twenty-nine members were present and 13 new members were inducted at this meeting. We now had delegates from county societies in Mason, Wood, Ohio and Lewis counties. On the second day a delegate from Cabell County was received. The Society now posed a resolution recommending the formation of county or district associate societies and stating that no petition for membership will be entertained unless the applicant is a member of the associate society or has a recommendation therefrom. At the evening meeting of the second day the representative member from the Cabell Society was expelled when it was learned he was an eclectic practitioner. The Cabell Society was notified it would not be continued as an associate society until it expurgated all irregular practitioners.

We now note the beginning of a long and never ending trend. The annual dues were raised from one to two dollars.

Dr. W. J. Bland of Weston was now elected President. Apparently the most important medical committee was the Committee on the Medical Botany of the State and its report was highly technical and reads like a college science text.

It was an old story: the Publication Committee was in the red $59.00; fortunately, it was not precedentary because the committee members advanced the $59.00, in order to keep the "transactions" in the black. We now had 86 members, two from Kanawha County.

* * * *

The fourth annual meeting was called to order by President W. J. Bland of Weston at the Court House in Martinsburg at 2 P. M., June 7, 1871. Sixteen members were present. The President gave a short history of the Society and it was now learned that a group of non-members had held a rump convention in 1869 in Point Pleasant for the purpose of organizing another medical society, but harmony and reconciliation evenutally cleared the atmosphere. Hence the resolution in Parkersburg, urging all regular practitioners to become regular members.

The preamble and resolution are worth repeating:

> "It having come to the knowledge of the Society that dissatisfaction exists in the minds of medical men in some parts of the State, arising from the fact that many physicians failed to receive invitations to take part in the organization of the Society, and hence had concluded the Society was formed in an exclusive spirit, and, for that reason, had declined to unite themselves with us; thereupon, Dr. Hildreth, of Wheeling, offered the following:

RESOLVED, That the Medical Society of the State of West Virginia was instituted, not in a partisan or exclusive spirit, but in the interest and for the benefit of the whole profession of the State; and regretting any and all causes of dissatisfaction, we hereby cordially invite every *regular* physician within the State, to unite with us in promoting the objects of the association, as set forth in the Constitution of the Society.

RESOLVED, That a committee of three members be appointed to correspond with and address circulars containing these resolutions to all regular physicians in the State."

This was a one-day convention, but there was an extensive scientific program. Papers were presented on microscopy in which it was stated "A professor of microscopy is as much needed in medical schools as a professor of anatomy." There were general remarks in public health and sanitary science and a long essay on anaesthetics, a short paper on Thermometry and Trichinosis and an extensive review by the Committee on Medical Botany.

We now had 98 members including Dr. James Putney of Kanawha Salines.

* * * *

The fifth annual meeting of the Medical Society of the State of West Virginia was held in Wheeling, June 5-7, 1872. The meeting was called to order by President J. M. Lazzell of Fairmont. Thirty-nine members answered the roll call. In the address of welcome, Dr. W. J. Bates stated:

"The signs of the times are such as to make it neither unreasonable nor presumptious to anticipate that organized medical influence will soon take a prominent part in controlling and directing legislative action in all matters having a bearing upon the public health.

The President deplored the amount of quackery dispensed by traveling doctors and stated that after passage of some medical legislation in Ohio, seven of the excluded physicians promptly moved to Wheeling, West Virginia. The Committee on Fee Bill, having submitted no report, was finally discharged. The Society made many visitations to museums, industries and Major Franzheim's wine cellar.

The Publication Committee, unable to make both ends meet, had a real inspiration. It solicited and procured advertising from druggists and instrument makers. To their surprise, the year ended with a surplus of $37.00, which was promptly handed over to the Treasurer. From this year, 1872, all publication committees have reacted in a similar manner. In good times they have fed the treasury; in times of stress, it is the old refrain, "Get rid of The Journal."

There was a report on the healing qualities of the Parkersburg Mineral Wells, attested to by five Parkersburg physicians: The report bore fruit, because the proprietor of the Springs Hotel requested that the next general meeting in Parkersburg be held at the Wells. There would be free entertainment for the doctors and their wives. Something happened, because the 1873 meeting was held at the Methodist Episcopal Church in Parkersburg.

* * * *

Dr. R. P. Davis of Parkersburg called to order the next annual meeting in Parkersburg, on June 4, 1873. Doctor Davis, Vice President, in appropriate remarks, referred to the Society's calamity in the death of its President, Dr. Robert H. Cummins.

The Secretary was directed hereafter to make a more precise report on membership to each annual meeting. This seems to have been a quiet session or the reporter had other things to do.

There was a scientific program which included; new remedies, medical botany, topography and epidemic diseases in Wood, Ritchie and Pleasants counties, trephining, vosico vaginal fistula and a case history of "Death from a Slung Shot."

* * * *

The seventh annual meeting was called to order by President M. S. Hall, of Harrisville at the Methodist Episcopal Church in Morgantown on May 27, 1874. The usual June date fixed by the By-Laws had been changed, because of conflict with the annual AMA Convention. Only 24 members answered the roll call.

The address of welcome by a local clergyman extolled the town of Morgantown, the University and the Female Seminary and it was stated the Medical Department of the University had the germ which it was hoped would soon expand into an active and useful college of medicine and surgery (some germ). Ten applications for membership were received and approved. President Alex Martin invited the members to meet with the faculty and students. In turn the Society respectfully recommended the establishment of a Chair of Anatomy, Physiology and Hygiene in order to furnish a more complete and useful education.

Delegates were appointed to the medical societies of Virginia, Pennsylvania, and Ohio.

The Committee on Publication recommended that the 1874 transactions be indexed and embrace the contents of the 1874 transactions and all previous issues (The present Publication Committee is grateful for the wisdom of the Publication Committee of 1874 and for the one copy of these combined transactions now in the archives of the society. From here to 1906 our knowledge of the state of the Medical Society of West Virginia is very spotty).

Because of the greatly increased paper work, the Secretary was granted an annual salary of $25.00. As of the last available record the B&O Railroad Company was still granting a free convention ride to all members.

The Secretary now reported there were 97 active members, a loss of seven since 1873.

The cumulative transactions, 1867-1874, indicate the birth and growth of our Medical Society. The progress was faltering at times, but always moving forward. To those who are interested in our archives, this volume can give you many refreshing hours or sleepless nights.

The scientific essays became stronger and better prepared as time went on. Reading the roster indicates an annual attendance of a small group of men, and with a few annual additions, it was the same names every year. The officers were the essayists or vice versa, but in seven years the list of speakers embraced all the regular attenders. The Presidential Address was always lengthy, but never tiresome. Its preparation must have taken all of the President's spare time during his tenure in office. Throughout the seven years there was not a "top name" or "outside speaker." This little self-sufficient group did very well by themselves.

(We have no "transactions" from 1874 to 1900. Can any member fill in some of the 26-year gap?)

(TO BE CONTINUED)

New Association Members

Dr. Robert L. Leadbetter, 308 33rd Street, S. E., Charleston (Kanawha). Doctor Leadbetter, a native of Marion Center, Pennsylvania, was graduated from West Virginia University and received his M. D. degree in 1959 from the Medical College of Virginia. He interned at Charleston Memorial Hospital, 1957-59, and served a residency at the same hospital, 1959-64. He also had postgraduate work at the M. D. Anderson Hospital and Tumor Clinic in Houston and the Massachusetts General Hospital in Boston. His specialty is surgery.

* * * *

Dr. Milan J. Packovich, Weirton Steel Co., Weirton (Hancock). Doctor Packovich, a native of Warren, Ohio, was graduated from Hiram College and received his M. D. degree in 1961 from the University of Chicago School of Medicine. He interned at the Guthrie Clinic and Robert Packer Hospital in Sayre, Pennsylvania, 1961-62, and served a residency at the Mayo Clinic, 1962-65. He was formerly located in Rochester, Minnesota, and his specialty is internal medicine and industrial medicine.

* * * *

Dr. Rigoberto Ramirez, 56 East Main Street, Buckhannon (Central W. Va.). Doctor Ramirez, a native of Mexico, received his M. D. degree in 1953 from the University of Mexico School of Medicine. He interned at the Methodist Hospital and Jackson Clinic in Madison, Wisconsin, 1956-57, and also served a residency at the same hospital. His specialty is surgery.

* * * *

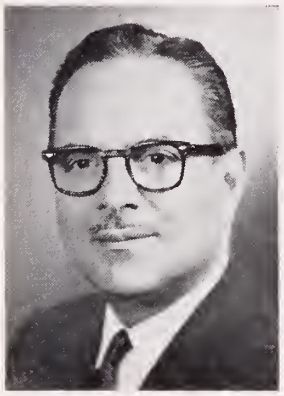
Dr. H. L. Saferstein, 16th and Eoff Streets, Wheeling (Ohio). Doctor Saferstein, a native of Elizabeth, New Jersey, was graduated from the University of Illinois and received his M. D. degree in 1958 from the University of Illinois School of Medicine. He interned at Wayne County General Hospital in Eloise, Michigan, 1958-59, and served a residency at the Skin and Cancer Hospital of Philadelphia, 1961-64. He served as a Captain in the Medical Corps of the United States Army, 1959-61. He was formerly located in Cinnaminson, New Jersey, and his specialty is dermatology.

* * * *

Dr. Cornelia B. Wilbur, Weston State Hospital, Weston (Central W. Va.). Doctor Wilbur, a native of Cleveland, was graduated from the University of Michigan and received her M. D. degree in 1939 from the University of Michigan School of Medicine. She interned at University Hospital in Ann Arbor, Michigan, 1939-40, and served a residency at the same hospital. She was previously located in New York City prior to accepting appointment as Superintendent of Weston State Hospital. Her specialty is psychiatry and neurology.

Assn. of Ophthalmology Elects Two W. Va. Physicians

Two members of the West Virginia State Medical Association were elected to executive offices during the meeting of the American Association of Ophthalmology in Chicago in October.



Albert C. Esposito, M. D.

Ralph W. Ryan, M. D.

Dr. Ralph W. Ryan of Morgantown was re-elected Treasurer, and Dr. Albert C. Esposito of Huntington, a Past President of the West Virginia State Medical Association, was named Secretary. Both will serve on the Executive Committee.

Among other officers named by the Association of Opthalmology were Dr. Barnet R. Sakler of Cincinnati, President; and Dr. Joseph M. Dixon of Birmingham, Alabama, President Elect.

The Association is now accepting membership applications from nonmember opthalmologists. Further information may be obtained by writing to the Executive Secretary, American Association of Ophthalmology, 1100 17th Street, N. W., Washington, D. C. 20036.

Trophoblastic Neoplasms Center Established at Duke

The Department of Obstetrics and Gynecology of the Duke University Medical Center has established the Southeastern Regional Center for Trophoblastic Neoplasms.

The Center is sponsored by a health service project grant award from the Department of Health, Education and Welfare, Division of Chronic Diseases.

The project in cancer control is established for the purpose of providing urinary gonadotropin assays and consultative assistance to physicians to aid in the evaluation of patients who have or are suspected of having abnormalities in trophoblastic tissue growth.

Physicians desiring gonadotropin assays for patients with placental abnormalities as molar degeneration, hydatidiform mole, syncytial endometritis, chorioadenoma destruens and choriocarcinoma may contact the Center at Durham, North Carolina.

Health Department Reports On Draft Rejectees

A total of 3,339 young men processed by armed forces examining stations serving West Virginia were disqualified for medical reasons during fiscal year 1965-66, State Health Director N. H. Dyer reported in a recent issue of the "State of the State's Health." This number represents 22.8 per cent of the total number of pre-inductees processed and is slightly above the national average.

Doctor Dyer explained that the Health Referral Service has interviewed 2,873 of these young men, discussing why they were rejected and encouraging them to seek medical care.

Although the unit does not have funds for rendering medical service, Doctor Dyer pointed out, it does have available information concerning all doctors and hospitals of the State along with complete knowledge of the medical services rendered by such agencies as Vocational Rehabilitation, the Department of Welfare, Crippled Children, Mental Health, the State Health Department, and charitable organizations. This information enables personnel to assist the medically disqualified young men to the most appropriate and conveniently located resource in his own community, Doctor Dyer explained.

During the first six months of the program in West Virginia, Doctor Dyer said, public health nurses were utilized as part of the Health Referral program at the community level. "The public health nurses on a part-time basis did an excellent job in starting the program and placed our State at the top in the number of cases serviced," Doctor Dyer commented.

In the last six months a gradual change has been made to full-time counselors who now occupy offices located in Charleston, Beckley, Fairmont, Elkins, and Huntington.

After one year of activity in the Health Referral Service program in West Virginia, Doctor Dyer stated, new insights have been gained in the health problems of young men 18 through 26. The most frequent diseases discovered among the disqualified youth were diseases of the eyes and ears, followed closely by diseases of the bones and joints, and cardiovascular problems. Doctor Dyer noted that this is slightly different from the national trend—the most frequent diseases are those of the bones and joints, followed by diseases of the eyes and ears and cardiovascular problems.

"Statistics show that the health of the young man who lives in the rural areas of our State is generally better than that of the ones living in urban areas," Doctor Dyer said. "Statistics also show that young men disqualified for psychological problems are more frequent in the cities than in the rural sections."

"In comparison with other states," Doctor Dyer concluded, "the West Virginia young man 18 through 26 is not quite as healthy as his counterpart.

In another issue of the "State of the State's Health" on the subject of Medicare, Doctor Dyer reported that an area survey showed no abnormal jump in patient loads in the hospitals since the inception of the new health program July 1.

Doctor Dyer pointed out that the fact that there was no "rush" to the hospitals demonstrates that none want to be hospitalized unless they really need to be and that doctors and hospitals are admitting patients for services only when medically necessary.

Arthritis Foundation Honors Dr. Daniel Hamaty

The Arthritis Foundation presented Dr. Daniel Hamaty of Charleston a distinguished service award during the group's 18th annual meeting in Washington, D.C., in October.

The award was one of 29 presented this year. A plaque cites Doctor Hamaty for his "outstanding service and support in the fight against America's number one crippling disease."

Doctor Hamaty, Director of Medical Education at Charleston Memorial Hospital, is President of the Charleston Branch of the West Virginia Chapter of the Arthritis Foundation. He is a member of the West Virginia State Medical Association and has been active in the work of the Association's Committee on Medical Education and Hospitals.

PG Course in Renal Disease

The American College of Physicians will sponsor a postgraduate course in "The Basic Mechanisms of Renal Disease" in New York City, January 16-20, 1967.

Fees include $60 for members of the ACP and $100 for nonmembers.

Additional information may be obtained by writing to Dr. Edward C. Rosenow, Jr., Executive Director, the American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

Miss Nimal L. Wijeyaratne, Secretary of Commerce of the Embassy of Ceylon, was guest speaker at the annual banquet of the 11th Annual Potomac-Shenandoah Valley Postgraduate Institute, which was held in Martinsburg, October 28-30. Miss Wijeyaratne is shown with Dr. L. Dale Simmons of Clarksburg (center), President of the West Virginia Chapter, American Academy of General Practice and Toastmaster for the banquet, and Dr. Halvard Wanger of Shepherdstown, Executive Secretary of the Institute. More than 300 persons, including 168 physicians, attended the Institute.

Cleveland Clinic Foundation Announces Courses

The Cleveland Clinic Educational Foundation will sponsor three postgraduate medical education courses during December and January.

The December-January schedule is as follows:

December 7-8—"Postgraduate Course in Ophthalmology."

January 11-12—"Advances in Dermatology."

January 18-19—"Controversies in General Surgery."

Additional information and detailed programs may be obtained by writing to the Director of Education, The Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106.

Two Physicians Elected Members Of W. Va. Legislature

Twe members of the West Virginia State Medical Association were elected to seats in the 100-member West Virginia House of Delegates for two-year terms in the general election on November 8.

Dr. John M. Bobbitt of Huntington, a urologist, was elected as a Republican to the six-member Cabell County delegation. Dr. Davis W. Ritter of Hinton was unopposed as a Democrat for Summers County's one seat in the House. Doctor Ritter specializes in surgery.

Dr. David W. Mullins of Logan, also a member of the Association, has two years remaining in his State Senate term and was not up for re-election this time.

PG Course in Pediatrics

A postgraduate course in Pediatrics will be conducted at the Medical College of Georgia in Augusta, December 8-9.

The course is sponsored by the Medical College of Georgia, the Medical Association of Georgia and the Georgia Academy of General Practice. It will be sponsored in part by a grant from the Children's Bureau of the U. S. Public Health Service.

Additional information may be obtained by writing to the Department of Continuing Education, Medical College of Georgia, Augusta, Georgia 30902.

Wanted: Medical Director For Welfare Department

The West Virginia Department of Welfare is vitally interested in obtaining the services of a physician for the position of medical director, either on a part-time or full-time basis.

The responsibilities of the position will include formulating medical policies and acting as liaison between the Department and medical and other groups.

Interested physicians should direct inquiries to Commissioner L. L. Vincent, Department of Welfare, The Capitol, Charleston, W. Va. 25305.

These surgeons participated in the Fall Surgical Meeting of the West Virginia Chapter of the American College of Surgeons which was held in Morgantown, October 28-29. Pictured left to right are: Dr. Irving F. Enquist, Professor of Surgery at the State University of New York, Down-State Medical Center; Dr. Theodore P. Mantz of Charleston, President of the State Chapter of the ACS; Dr. Theodore Drapanas, Professor of Surgery at the University of Pittsburgh School of Medicine; Dr. Bernard Zimmermann, Chairman of the Department of Surgery, WVU School of Medicine; Dr. Harry Cooper of Beckley, Vice President of the State Chapter of ACS; and Dr. Ward Griffen, Jr., Associate Professor of Surgery, University of Kentucky School of Medicine.

Dr. Edward J. Van Liere Completes Book

Dr. Edward J. Van Liere of Morgantown, retired Dean of the West Virginia University School of Medicine, has completed a new book entitled "Medical and Other Essays."

The volume was published in October by the West Virginia University Library. It contains 170 pages with eight pages of illustrations.

The book contains 34 essays on various topics. Some of the titles are: "College Presidents"; "Creative Ideas in Biologic Research"; "Tenure of Medical Deans"; "Retirement"; and "Dr. John H. Watson and the Subclavian Steal." Also included are a number of biographical sketches.

The price of the book is $5.00. Each alumnus of the School of Medicine who is current in his dues will receive a free copy.

Motion Picture on Drug Abuse

The U. S. Public Health Service has announced the release of a 20-minute sound film entitled "FDA Special Report: Drug Abuse—Bennies and Goofballs."

The black and white 16 mm film is designed to discourage human experimentation with drugs without the supervision of a physician. It is suitable for showing to the general public.

Prints of the film are available free of charge on a short-term loan basis from the Public Health Service Audiovisual Facility, Atlanta, Georgia 30333, Attn.: Distribution Unit; or they may be purchased from Precision Film Laboratories, 21 West 46th Street, New York 36, New York.

Dr. Richard E. Flood of Weirton, President of the West Virginia State Medical Association, made his official visit to the Logan County Medical Society on November 9. Shown in picture are (left to right): Dr. Mark Spurlock, Secretary of the Society; Doctor Flood; and Dr. Thomas P. Long, Acting President of the Society.

Government Clinical Center Study Of Hodgkin's Disease

The National Institutes of Health submitted the following item for publication in *The Journal*:

The cooperation of physicians is requested in a continuing study of Hodgkin's disease being conducted by the National Cancer Institute at the Clinical Center, National Institutes of Health, Bethesda, Maryland.

Particularly desired are patients who have had no previous treatment or minimal prior treatment. All clinical stages of biopsy-proven disease are acceptable. The major purpose of the study is to determine the curative potential of intensive radio-therapy in localized cases and to evaluate combination chemotherapy and x-irradiation in patients with generalized involvement.

Physicians interested in having their patients considered for the study may phone or write to: Paul P. Carbone, M. D., The Clinical Center, National Institutes of Health, Building 10—Room 12-N-228, Bethesda, Maryland 20014.

Gill Hospital Presents PG Program

The staff of Gill Memorial Eye, Ear, Nose and Throat Hospital will present a symposium in Roanoke, Virginia, on December 2.

The program will relate to the diagnosis and management of common problems in eye, ear, nose and throat as seen by the physician.

Guest faculty will include Dr. Peter Pastore of the Medical College of Virginia and Dr. M. K. Humphries, Jr., of the University of Maryland School of Medicine.

Television: A medium of entertainment that brings members of the family into the same room so they can ignore each other close together.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1966

Dec. 1—Am. Epilepsy Soc., New York City.
Dec. 2-3—Am. Rheumatism Assn., Cincinnati.
Dec. 3-6—Am. Acad. for Cerebral Palsy, New Orleans.
Dec. 3-8—Am. Acad. of Dermatology, Bal Harbour, Fla.
Dec. 4-7—Am. Soc. of Hematology, New Orleans.
Dec. 6-8—Southern Surgical Assn., Boca Raton, Fla.

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Jan. 14-19—Am. Acad. of Orthopaedic Surgeons, San Francisco.
Jan. 20-21—ACP Regional Meeting, Morgantown.
Jan. 22-23—AMA Nat. Cong. on Socio-Economics of Health Care, Chicago.
Jan. 23-25—Soc. of Thoracic Surgeons, Kansas City.
Jan. 31-Feb. 4—Am. Col. of Radiology, Chicago.

Feb. 8-10—Am. Acad. of Occupational Med., San Francisco.
Feb. 9-15—AMA Cong. on Med. Ed., Chicago.
Feb. 14-19—Am. Col. of Cardiology, Washington.
Feb. 18-22—Am. Acad, of Allergy, Palm Springs, Calif.
Feb. 23-25—Cen. Surg. Assn., Pittsburgh.
Feb. 28—Nat. Multiple Sclerosis Soc., New York.

March 9-11—AMA-ABA National Medicolegal Symposium, Miami Beach.
March 10-11—AMA Conf. on Rural Health, Charlotte, N. C.
March 16-18—Sou. Soc. of Anesthesiologists, Charleston, S. C.
March 19-24—Southeastern Surgical Cong., Bal Harbour, Fla.
March 19-24—Am. Col. of Allergists, New Orleans.

April 3-5—Am. Acad. of Ped., San Francisco.
April 7-9—Am. Soc. of Int. Med., San Francisco.
April 10-13—Indus. Med. Assn., New York City.
April 10-14—Am. Col. of Physicians, San Francisco.
April 16-20—Am. Col. of Ob. & Gyn., Philadelphia.
April 17-19—Am. Assn. for Thoracic Surgery, New York.
April 19-21—Maryland Medical, Baltimore.
April 23-26—W. Va. Acad. of Oph. and Otol., White Sulphur Springs.
April 27-28—Am. Ped. Soc., Atlantic City.
April 30-May 2—W. Va. Chapter, AAGP, Huntington.
April 30-May 5—Int. Col. of Surgeons, Bal Harbour, Fla.

May 2-3—Assn. of Am. Phys., Atlantic City.
May 3—Am. Cancer Soc., Dallas.
May 4-6—Am. Gynecological Soc., Phoenix.
May 6—Am. Col. of Psychiatrists, Philadelphia.
May 11-14—Am. Surg. Assn., Colorado Springs.
May 16-19—Ohio Medical, Columbus.
May 28-June 1—Am. Dermatological Assn., Colorado Springs.
May 29-June 1—Am. Urol, Assn., New York.
May 21-24—Am. Thoracic Soc., Pittsburgh.

June 15-17—Am. Col. of Chest Phys., Atlantic City.
June 17—Acad. of TB Phys., Atlantic City.
June 17-18—Am. Diabetes Assn., Atlantic City.
June 18-22—AMA Annual Con., Atlantic City.

Aug. 24-26—100th Annual Meeting, W. Va. State Medical Assn., The Greenbrier, White Sulphur Springs.

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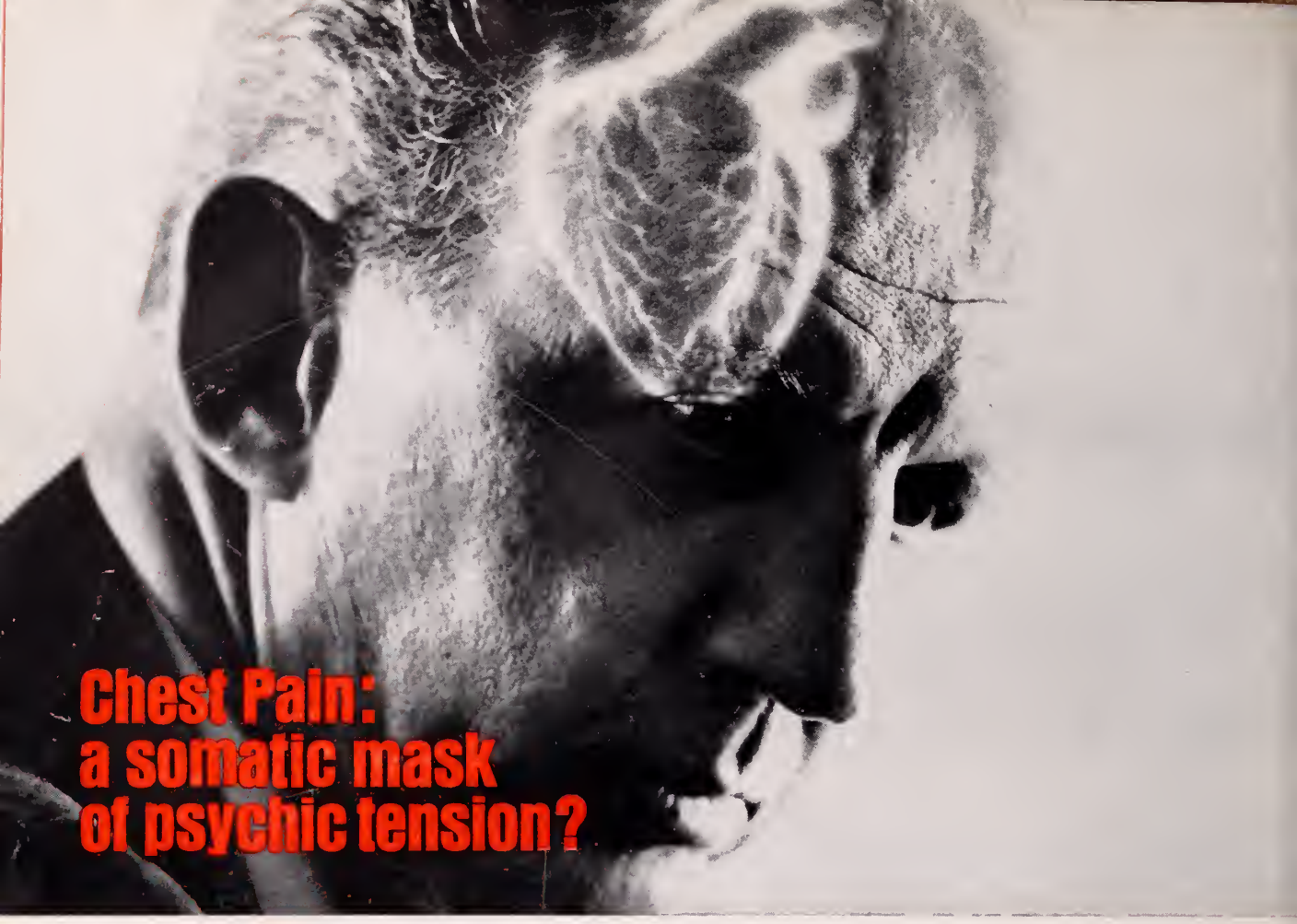

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